Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Meeting of the Foundation Trust Board of Directors
Wednesday 27th July 2016
Romero Centre, Macclesfield, Cheshire
2.00pm

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
16/17/27	Apologies for absence	Receive apologies	Verbal	Chair	1 min (1400)
16/17/28	Declarations of Interest	Identify and avoid conflicts of interest	Verbal	Chair	2 min (1401)
16/17/29	Minutes of the previous meeting held 25th May 2016	Confirm as an accurate record the minutes of the previous meetings	Written minutes	Chair	2 mins (1403)
16/17/30	Matters arising and action points	Provide an update in respect of ongoing and outstanding items to ensure progress	Written action schedule and verbal update	Chair	2 mins (1405)
16/17/31	Board Meeting 2016/17 business cycle	Confirm that agenda items provide assurance that the Board is undertaking its duties	Written	Chair	3 mins (1407)
16/17/32	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	10 mins (1410)
16/17/33	Chief Executive's announcements *(including overview of items discussed in closed meeting)*	Announce items of significance not elsewhere on the agenda	Verbal	Chief Executive	10 mins (1420)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
MATTERS FOR APPROVAL/ DECISION					
Strategy					
16/17/34	Suicide Reduction Partnership	To update on partnership work	Written	Medical Director	15 mins (1430)
16/17/35	Person Centred Framework	To update on framework development	Written	Director of Nursing, Therapies and Patient Partnership	15 mins (1445)
Capability and Culture					
16/17/36	Six monthly Safer Staffing report	To note six monthly report	Written	Director of Nursing, Therapies and Patient Partnership	15mins (1500)
Process and Structures					
16/17/37	Daily Ward Staffing figures May & June 2016	To note the Daily Ward Staffing Figures	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1515)
16/17/38	Update on Southern Health action plan	To update on the action plan	Written Report	Director of Nursing, Therapies and Patient Partnership	10 mins (1525)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
16/17/39	2015/16 Infection, Prevention and Control Annual Report	To note the annual report	Written Report	Director of Infection, Prevention and Control	10 mins (1535)
16/17/40	2015/16 Safeguarding Annual Report	To note the annual report	Written	Director of Nursing, Therapies and Patient Partnership	10mins (1545)
16/17/41	2015/16 Medicines Management Annual Report	To note the annual report	Written	Medical Director	10mins (1555)
16/17/42	Medical Appraisal and revalidation report	To approve the report for submission to NHS England	Written	Medical Director	10mins (1605)
Measurement					
16/17/43	NHSI Oversight Framework consultation	To review framework and impacts	Written	Director of Finance	5 mins (1615)
16/17/44	Q1 2016/17 NHSI submission	To review and approve declarations and submission	Written Report	Director of Finance	5 mins (1620)
Governance					
16/17/45	Well led governance review update	To update on progress with review	Written Report	Medical Director/ Head of Corporate Affairs	10mins (1625)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
16/17/46	Corporate Governance Manual (CGM): annual review	To approve CGM review amendments	Written	Director of Finance	5mins (1635)
16/17/47	CQC Statement of Purpose	To approve amendment	Written	Medical Director	5 mins (1640)
16/17/48	Audit Committee reporting: • Chair's report of meeting held 24th May and 5th July 2016 • 2016/17 Terms of Reference	Review Chair's Report and terms of reference and any matters for note/ escalation	Written	Chair of Audit Committee	3 mins (1645)
16/17/49	Quality Committee reporting : • Chair's report of meeting held 6th July 2016	Review Chair's Report and any matters for note/ escalation	Written	Chair of Quality Committee	3 mins (1648)
16/17/50	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair/ All	5 mins (1651)
16/17/51	Any other business	Consider any urgent items of other business	Verbal or written	Chair	2 mins (1656)
16/17/52	Review of meeting	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair/All	2 mins (1658)

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time allocated to item
16/17/53	Date, time and place of next meeting: **Wednesday 28th September, 2.00pm Boardroom, Redesmere.**	Confirm arrangements for next meeting	Verbal	Chair	1700

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Minutes of the Open Board of Directors Meeting
Wednesday 25th May 2016
Boardroom, Redesmere commencing at 1.30pm

PRESENT	David Eva, Chair Sheena Cumiskey, Chief Executive Dr Jim O'Connor, Non-Executive Director Mike Maier, Deputy Chair and Non-Executive Director Dr Anushta Sivananthan, Medical Director Andy Styring, Director of Operations Rebecca Burke – Sharples, Non-Executive Director Fiona Clark, Non-Executive Director Tim Welch, Director of Finance Lucy Crumplin, Non-Executive Director Avril Devaney, Director of Nursing, Therapies and Patient Partnership Dr Faouzi Alam, Medical Director Sarah McKenna, Non-Executive Director	
IN ATTENDANCE	Louise Brereton, Head of Corporate Affairs David Harris, Director of People and Organisational Development Andrea Hughes, Director of Infection, Prevention and Control (for item. 16/17/14 and 16/17/15) Phil Jarrold, Service User/ Carer Governor Peter Wilkinson, Public Governor	
APOLOGIES	None	
REF	**MINUTES**	**ACTION**
16/17/01	**APOLOGIES FOR ABSENCE** The Chair welcomed all to the meeting. There were no apologies to note and the meeting was quorate.	
16/17/02	**DECLARATIONS OF INTEREST** No declarations of interest were noted.	
16/14/03	**MINUTES OF THE PREVIOUS MEETING HELD 30TH MARCH** The minutes of the meeting held 30th March 2016 were **approved** as a correct record.	
16/17/04	**MATTERS ARISING AND ACTION POINTS** All action points had been completed, were in progress or were noted on the agenda. Avril Devaney commented as a matter arising that the Person Centred Framework briefly mentioned at the March meeting would be introduced for consultation at the Annual Members Meeting on 22nd September 2016.	

16/17/05	**BOARD 2016/17 BUSINESS CYCLE** The Board noted the business cycle for 2016/17.	
16/17/06	**CHAIR'S ANNOUNCEMENTS** The Chairman announced the following: **Press coverage** During April and May so far, CWP has 40 pieces of coverage in newspapers, online and in local newsletters. CWP has been regularly featured on local radio including BBC Radio Merseyside and Wirral Radio. Dr Fiona Pender has recently been featured in the Guardian to discuss underfunding in children's mental health. **'Team of Life' tool** A new tool designed by CWP to support children and young people's mental health will receive a boost of over £130,000 following Health Education England (HEE) and Department of Health funding. **Nursing Framework launch** Led by Director of Nursing and Therapies Avril Devaney, nurses across CWP came together to be part of the launch of the new Nursing Framework 'Leading Change Adding Value'.	
16/17/07	**CHIEF EXECUTIVE ANNOUCEMENTS** Sheena Cumiskey provided an overview of the items discussed during the closed session. These included • The Trust work with Western Cheshire CCG to ensure CWP has sufficient resources for safe and effective community physical health services. • Operational planning and the agreement of the delivery indicators framework. • Board's consideration of options to improve on the Trust's cash position. • The month 1 2016/17 financial position.	
16/17/08	**ANNUAL REPORT, ACCOUNTS AND QUALITY ACCOUNT 2015/16** Mike Maier, Chair of Audit Committee introduced the Annual Report, Accounts and Quality Account 2015/16 to the Board. The Audit Committee had met on 24th May to receive the auditor's opinions on the 2015/16 audit. The Committee had been informed by KMPG that the audit had been a smooth undertaking, with only one small adjustment required. Louise Brereton advised on a number of immaterial revisions to the Annual Report since the draft was circulated to Board members. These included additional information to the enhanced quality governance section, code of governance disclosures, an explanatory note to the remuneration table regarding pension benefits and a number of alterations to page numbering	

	and referencing. The Board were advised that the final submission would be subject to a full consistency check. A clean, unqualified opinion had been issued by the auditors for both the Annual Report and Accounts and for the Quality Account. Sarah McKenna commented as a relatively new NED to the Board having recently joined the Audit Committee membership, the opinions from KPMG were very pleasing and assuring in regard to financial stewardship and process management. The Board noted that these opinions had been achieved during what had been a demanding year with the comprehensive CQC inspection and the financial challenges. Commenting on the audit process, this had benefited from an earlier and more mature dialogue on the approach. The improvements in data quality achieved in the year were also noted as a particular achievement. The Board extended thanks to Andy Harland, Mike Lloyd and the finance team, David Wood and Louise Brereton for their work in finalising the submission. Mike Maier, Chair of Audit Committee commended the Annual Report, Accounts and Quality Account 2015/16 to the Board for approval. The Board resolved to **approve** the Annual Report, Accounts and Quality Account 2016/17.	
16/17/09	**MENTAL HEALTH FUNDING – BOARD RESOLUTION** Sheena Cumiskey tabled a report which set out a draft Board resolution statement following the discussions at previous Board meetings confirming Board appetite for a formal board statement regarding the lack of adherence to the 2016/17 planning guidance regarding growth monies. The report included an appendix document setting out the financial impact. It was confirmed that only Wirral CCG has honoured the full commitment to the planning guidance uplift. Sheena Cumiskey advised the Board of the resolution as follows: *'The Board note with disappointment the failure of the CCGs to implement the planning guidance 2016/17 to commit the same proportion of their growth to mental health services. The Board does not believe that this supports the objective of parity of esteem and is discriminatory to people requiring mental health care.* *The Board resolve to raise this issue locally and nationally and to continue to work with its governors to continue to address the underfunding of mental health, learning disability and physical community services.* *In terms of provider allocations, CWP recognise that CCGs can invest in mental health services through funding a range of providers in addition to CWP, however the HFMA/ NHS providers' analysis findings suggest that cross provider funding to fully meet mental health commitments has not*	

	been in place in 2015/16. The Board confirmed their support to the statement. A discussion ensued regarding the circulation of the statement. It was confirmed that this will be circulated to politicians, stakeholders and members of the voluntary sector. The communications team will also work with the media to publicise the resolution. The Board agreed that offering the CCGs a right of response would be politic in the first instance. It was also suggested that information be shared on what the position would have been had the planning guidance growth monies been allocated with benchmarking information as additional context. Dr Anushta Sivananthan commented that the Board resolution supports the CCG benchmarking information on mental health allocations. The overall spend on mental health is around 13%. Wirral and West CCG position was approx. 12%, East Cheshire CCG at 10%, South Cheshire CCG at 10% and Vale Royal at 9%. This was a 2013/14 position with more updated information is due for release shortly. The Board resolved to **approve** the Board resolution regarding mental health funding. (Dr Faouzi Alam left the meeting)	
16/17/10	**BOARD PERFORMANCE DASHBOARD – APRIL 2016 DATA** Tim Welch updated the Board on the following issues: • The IAPT 18 week has been achieved in April 2016. There are issues with compliance in East Cheshire which is being addressed as IAPT has been identified as one of the six 16/17 priority areas. • The timescale for outcome of inpatient bed review is subject to Board approval in June 2016. The Board resolved to **note** the report.	
16/17/11	**TRUST PROVIDER LICENCE COMPLIANCE** Tim Welch introduced the report setting out the Q415/16 position for compliance with the Trust licence. Two areas have been rated as not fully compliant. These concerned the Trust's work on the choice agenda and in publishing appropriate referral and eligibility criteria. Both areas have an action plan in place. Tim Welch advised the Board that a number of Board declarations are required in line with Licence compliance. These were: • Declaration in accordance with General Condition 6 (systems in place for compliance with the Licence conditions) • Declarations in accordance with section 6, condition FT4 (NHS FT governance systems). This concerns approval of the corporate governance statements, assurance regarding appropriate training for governors and assurances for Trusts with significant joint ventures or Allied Health Science Networks. The Board reviewed the declarations and supporting evidence. The declarations were approved by the Board. The Board were reminded that	

	these will be submitted by the end of May 2016 and end of June 2016 respectively. The Board resolved to: • **Note** the Q4 15/16 Licence assessment • **Approve** and confirm the declarations in accordance with General Condition 6 and Condition FT4 of the Licence for submission to NHS Improvement.	
16/17/12	**PEOPLE AND ORGANISATIONAL DEVLEOPMENT** **a. Review of Appraisal Process** David Harris presented the report and reminded the Board that the appraisal process had been subject to a recent review. The review had concluded that the Trust should be a seeking a 100% compliance rate for appraisal and this could happen through moving to an annual appraisal cycle to enable individual objectives to be aligned to the Trust's strategy and objectives. The revised approach will support staff to have greater understanding of approach to appraisal and to have a greater linkage to leadership and management development, as well as ensuring and maintaining the wellbeing of staff. Lucy Crumplin commented that the new process was not aligned to the KSF and queried whether this was a risk in reducing rigour in the process. David Harris commented that the approach aligned to the KSF was not widely used, and staff were using a range of different processes and formats for appraisal. The new approach will allow standardisation and consistency and will focus on performance. Sarah McKenna queried the level of digitalisation within the process. It was confirmed that at this time, only the reporting mechanism is digitalised, however plans are in place to electronic solution in the near future. Sarah McKenna suggested that moving to a digital platform need not be time consuming and has the potential to engage more staff from the outset. David Harris confirmed commitment to the digital solution but advised that further time and work was needed to appropriately plan for this. Dr Jim O'Connor commended the change in approach. It was confirmed that the Board will receive reports on a quarterly basis on rates of compliance and quality outcomes. An end of year will also report on quality. Rebecca Burke Sharples supported the proposals but queried how achievable the targets were without any additional resources to support this. David Harris advised that the revised approach had been presented to and discussed at the Operational Board meeting and the feedback received had been taken account of in the report provided to the Board. (Dr Faouzi Alam re-joined the meeting) It was noted that there is potential to adapt this approach for Non-Executive Directors. .	

	Action: LB and MM to take this forward. **b. POD Delivery Plan 2016/17** David Harris advised the Board that the People and OD delivery plan for 2016/17 sets out the strategy objectives and breaks them down into deliverables. It is an ambitious plan but all deliverables have been agreed with lead officers. The delivery plan is monitored on a monthly basis at the People and OD sub-committee. The indicators are reflected in the Operational Plan monitoring indicators and will be presented to the Board in accordance with the thresholds agreed. The Board resolved to **note** the reports.	**MM/LB**
16/17/13	**CORPORATE ASSURANCE FRAMEWORK, RISK REGISTER AND INTEGRATED GOVERNANCE FRAMEWORK** Dr Anushta Sivananthan updated the Board on the changes to the risk register and assurance framework. A number of new risks are in scope, these included: • Junior doctor cover for psychiatry. • Impact of IAPT waiting times • Impact of the apprenticeship levy operationally and financially • Staffing levels in physical health community teams – visibility, capacity and intensity of caseload due to complexity of need. All risks in scope are under discussions with risk leads and will report to the July Quality Committee. In terms of existing risks, the data quality risk is current under re-modelling to ensure it accurately reflects the current picture. The cash risk also requires further work on the risk treatment plan. A programme targeting the longer standing Trust risks has commenced to either remodel or archive these risks. Meetings are being held with risk leads individually to appropriately assess the position with each risk. The Board resolved to: • **Approve** the amendments to the corporate assurance framework • **Approve** that the review of the corporate assurance framework takes place on a quarterly basis from 2016/17. (Andrea Hughes joined the meeting)	
16/17/14	**FREEDOM TO SPEAK UP GUARDIAN – 2015/16 ANNUAL REPORT** The Chair welcomed Andrea Hughes, Director of Infection, Prevention and Control to the meeting. Andrea Hughes introduced the first Freedom to Speak Up annual report and provided an overview of the processes that have been implemented to adhere to the regulations. Significant work has been undertaken to promote the Freedom to Speak Up role within services and there is definite visibility of this in localities.	

	2015/16 has shown an increase of 13 'speak ups' since the previous year. This is a pleasing position as it indicates that the service is known about and is understood. The expectation is that these numbers will increase each year. Reporting on the themes arising from the concerns raised, Andrea Hughes commented that the greatest theme is staffing concerns. Actions have been taken in response to concerns and this includes ward culture assessments including a 360 process to investigate issues. Individual services are also responsible for responding to areas of concern. Andrea Hughes advised that as a next step, the Trust is seeking to develop ambassador roles to signpost and support people if they want to raise a concern. An education package is also in development to support understanding on why people should raise concerns and what they can do about this. Andrea Hughes updated that the national Freedom to Speak Up Guardian is hosted by the CQC but sits independently of them. The national post is in the process of being appointed to following the resignation of the previous incumbent. The Trust works closely with Freedom to Speak Up representatives in other Trusts and discussions with them suggest that the CWP process is well developed in comparison to others. The next steps for the Trust are to continue to develop a culture of openness and to do more to address concerns once they have been raised. There is also a need to appoint a new NED champion for the Freedom to Speak Up agenda. This was previously David Eva; however a new appointee will need to be identified to take this forward from June 2016. Training is available for NEDs involved in this work. **Action** - Mike Maier to consider with NED colleagues. The Board resolved to **note** the report.	**MM**
16/17/15	**Q4 2015/16 INFECTION, PREVENTION AND CONTROL ANNUAL REPORT** Andrea Hughes presented the Q4 2015/16 report and advised that the quarter has strongly focused on anti-microbial processes. In particular, work has been taken forward with pharmacy colleagues following any anti-microbial prescribing to ensure it is in line with formularies and is appropriate. Reporting on sepsis which has been a significant media issue recently, there has been a drive from NICE on dealing with sepsis. This is not a significant issue for CWP but staff need awareness of the risks and issues. One CWP patient recently was diagnosed with sepsis and was transferred to the acute hospital. A plan is in place to take forward over the 12 months focusing on education and awareness raising. Dr Jim O'Connor commented that prevention and early identification of sepsis in the community is essential. Andrea Hughes advised that an e-learning module is being developed to ensure this area is appropriately	

	covered which the Trust has contributed to the development of. The module will be extended to staff in the out of hours service as awareness of sepsis is an important issue for them. The Board resolved to **note** the report. (Tim Welch left the meeting)	
16/17/16	**DAILY WARD STAFFING FIGURES, MARCH AND APRIL 2016** Avril Devaney updated the Board on recent ward staffing figures for March and April 2016. Croft ward has been an outlier recently due to a recent high level of staff sickness and other staff not being able to work there due to their physical health issues. In April, the difficulties were overcome and this was reflected in the improved figures reported. Dr Jim O'Connor agreed that the overall picture improved in April in comparison to March however queried the low staffing levels on Brooklands and Beech wards. Avril Devaney reminded the Board that the figures reflect the nursing staff only and not the wider MDT on the ward. There is no additional evidence that there are any issues on these wards. The next six monthly staffing report is due at the July 2016 Board meeting which provides a broader overview of the full staffing complement on the wards. The Board resolved to **note** the report.	
16/17/17	**WORCESTERSHIRE SERIOUS CASE REVIEW (SCR)** Avril Devaney updated the Board on further developments since the publication of a Serious Case Review by Worcestershire Local Safeguarding Children Board. The report was provided to Board members in April 2016. The review pertained to a former patient of Greenways and an incident which had occurred a significant time after the patient had left CWP care. Since the publication of the report, CWP had identified actions and had implemented these independently. No actions were identified by the LSCB for CWP. This case was reviewed by CQC during the comprehensive inspection in 2015 and they were satisfied with how the case was handled. Andy Styring commented that CWP had provided care to the individual at the request of the commissioner and NHS England. CWP has taken learning from this case around ensuring our processes are sound in these exceptional cases. The Board resolved to **note** the report.	
16/17/18	**LEARNING FROM EXPERIENCE REPORT – EXECUTIVE SUMMARY** Avril Devaney introduced the Learning from Experience report and the following points were noted: • The Heinrich ratio is used as a measurement of variation in the proportion of harmful incidents. There is further to do to reduce these in relation to adherence to the ideal Heinrich ratio • In the recent publication of the learning from mistakes league,	

	CWP were rated as 68 from 131 trusts on our levels of openness. • Focus on efforts to progress quality improvement project with support from CWP Education. • In line with the zero harm strategy, a patient safety management system approach has been approved by Quality Committee • 84 complaints have been received and the report sets out how these have been responded to. Sheena Cumiskey advised that there is a need to further ensure that the learning from experience report is shared widely across the organisation and partners. The Board resolved to **note** the report.	
16/17/19	**STATUTORY REGISTERS** Louise Brereton advised the Board that the Corporate Governance Manual requires that the Directors and Governors Register of Interests are noted by the Board on an annual basis. Louise Brereton advised that the Trust also maintains a register of Directors' adherence to the Fit and Proper Persons regulations. The Board resolved to **note** the Directors Register of Interests, Governors Register of Interests and the Fit and Proper Persons Register.	
16/17/20	**CHIEF EXECUTIVE AND CHAIR: ANNUAL REVIEW OF DIVISION OF RESPONSIBILITIES** Louise Brereton advised that in accordance with the corporate governance manual, the division of responsibilities for the Chair and the Chief Executive must be set out in writing and be reviewed on an annual basis and subsequently noted by the Board. This has been recently reviewed by Sheena Cumiskey and Mike Maier and some minor amendments made. The Board resolved to **note** the report.	
16/17/21	**AUDIT COMMITTEE REPORTING: CHAIRS REPORT OF THE MEETING HELD 3RD MAY 2016 AND ANNUAL REPORT 2015/16** Mike Maier provided an overview of the key issues arising from the recent meeting of the Audit Committee. The Annual Report was also provided for note. The Board resolved to **receive** the Chair's Report and Annual Report.	
16/17/22	**QUALITY COMMITTEE REPORTING: CHAIR'S REPORT OF THE MEETING HELD 4TH MAY 2016 AND TERMS OF REFERENCE** Dr Jim O'Connor provided feedback on QC effectiveness review and gave an overview of the issues arising at the recent meeting. The Board resolved to **receive** the Chair's Report and **approved** the Terms of Reference.	

16/17/23	**REVIEW OF RISK IMPACTS OF ITEMS DISCUSSED** There were no further items of risk identified.	
16/17/24	**ANY OTHER BUSINESS** It was noted that this was David Eva's final Board meeting as Chairman of the Trust. The Board extended their heartfelt thanks to David for his many years of service to the Trust and offered their very best wishes in his new appointment as Chairman of Lancashire Care FT. The Chair offered members of the public an opportunity to comment on the afternoon's proceedings.	
16/17/25	**REVIEW OF MEETING** All agreed the meeting had been effective**.**	
16/17/26	**DATE, TIME AND PLACE OF NEXT MEETING:** Wednesday 27th July, 2.00pm, Romero Centre, Macclesfield.	

Cheshire and Wirral Partnership NHS
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Action points from Board of Directors Meetings
May 2016

Date of Meeting	Minute Number	Action	By when	By who	Progress Update	Status
25.05.16	16/17/12	**PEOPLE AND OD: APPRAISAL PROCESS** To consider new approach to staff appraisal when reviewing NED appraisal process	July 2016	MM/ LB		Open
25.5.16	16/17/14	**FREEDOM TO SPEAK UP GUARDIAN** The Trust requires a NED 'champion' for the Freedom to Speak Up process. MM to progress with NED colleagues	July 2016	MM	NED nominated for appointment. To be noted at July 2016 Board meeting.	Open

Cheshire and Wirral Partnership NHS Foundation Trust
Board of Directors meeting Business Cycle 2016/17

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

No:	Agenda Item	Executive Lead	Responsible Committee/ Subcommittee	27/04/2016 Seminar	25/05/2016	29/06/2016 Seminar	27/07/2016	28/09/2016	26/10/2016 Seminar	30/11/2016	22/12/2016 Seminar	25/01/2017	22/02/2017 seminar	29/03/2017
Well Led Domain 1: Strategy														
1	**Operational Plan 2017-18approval of submission**	Director of Finance	Operational Board											✓
2	**Receive Annual Report, Accounts and Quality Account**	Director of Finance	Audit Committee (Quality Committee for QA)		✓									
3	**Integrated Governance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee					✓						
4	**Quality Reports**	Medical Director Compliance Quality and Regulation	Quality Committee		✓			✓		✓		✓		
5	**Strategic Risk Register and Corporate Assurance Framework**	Medical Director Compliance Quality and Regulation	Quality Committee		✓			✓		✓		✓		
Well Led Domain 2: Capability and Culture														
6	**CQC Community Patient Survey Report 2015/16 and Action Plan**	Director of Nursing, Therapies and Patient	Operational Board					✓						
7	**Equality Act Compliance**	Director of Nursing, Therapies and Patient	Operational Board					✓						
8	**Zero Harm strategy reporting**	Medical Director Compliance Quality and Regulation	Quality Committee				✓							✓
9	**Staff survey 2015/16**	Director of HR and OD	People and OD subcommittee (Operational Board)											✓
10	**Six monthly staffing review**	Director of Nursing, Therapies and Patient	Quality Committee/ Operational Board				✓					✓		
Monitor Well Led Domain 3: Process and Structures														
11	**Receive and Approve Quarterly Monitor returns**	Director of Finance	N/A	✓			✓		✓			✓		
12	**Receive Learning from Experience Report executive summary**	Director of Nursing, Therapies and Patient Partnership	Quality Committee		✓			✓				✓		
13	**Assessment of Quality Governance**	Medical Director Compliance Quality and Regulation	Quality Committee		✓		✓		✓			✓		
14	**Declarations of Interest: Directors and Governors**	Chair	Audit Committee		✓									
15	**CEO /Chair Division of Responsibilities**	Chair	N/A											✓

16	**Care Quality Commission Registration Report**	Director of Finance	Operational Board									✓		
17	**Receive Quarterly Infection Prevention Control Reports**	Director of Infection Prevention and Control	Infection, Prevention and Control subcommittee (Quality Committee)		✓			✓		✓		✓		
18	**Director of Infection Prevention and Control Annual Report 2015/16 inc PLACE**	Director of Infection Prevention and Control	Infection, Prevention and Control subcommittee (Quality Committee)				✓							
19	**Safeguarding Children Annual Report 2015/16**	Director of Nursing, Therapies and Patient Partnership	Safeguarding subcommittee				✓							
20	**Quartely Safeguarding Report**	Director of Nursing, Therapies and Patient Partnership	Safeguarding subcommittee				✓	✓		✓		✓		
21	**Safeguarding Adults Annual Report 2015/16**	Director of Nursing, Therapies and Patient Partnership	Safeguarding subcommittee				✓							
22	**Accountable Officer Annual Report inc. Medicines Management 2015/16**	Medical Director Compliance Quality and Regulation	Medicines Management Group (Quality Committee)				✓							
25	**Health and Safety Annual Report and Fire 2015/16 and link certification**	Director of Nursing, Therapies and Patient Partnership	Health, Safety and Well-being subcommittee (Operational Board)				✓							
26	**Receive Appraisal Annual Report 2015/16 and annual declaration of medical revalidation**	Medical Director of Effectiveness and Medical Workforce	People and OD subcommittee (Operational Board)				✓							
23	**Emergency Planning Annual Report 2015/16**	Director of Nursing, Therapies and Patient Partnership	Emergency Planning subcommittee (Operational Board)					✓						
24	**Monthly Ward Staffing update**	Director of Nursing, Therapies and Patient	Quality Committee		✓		✓	✓		✓		✓		✓
25	**Provider Licence Compliance**	Director of Finance	Audit Committee		✓					✓				
26	**Security Annual Report 2015/16**	Director of Operations	Health, Safety and Well-being subcommittee (Operational Board)					✓						

27	**Mental Health Act compliance report (KP90)**	Medical Director Compliance Quality and Regulation	Compliance, Assurance and Learning subcommittee (Quality Committee)		✓					✓					
28	**Receive Register of Sealings Report**	Director of Finance	Audit Committee					✓							
29	**Receive Research Annual Report 2015/16**	Medical Director Effectiveness Medical Education	Operational Board					✓							
	Monitor Well Led Domain 4: Measurement														
30	**Information Governance 15/16 Toolkit**	Medical Director	Records and Clinical Systems Group (Quality Committee)												✓
31	**Board Performance Dashboard**	Director of Finance	Operational Board		✓		✓	✓		✓		✓		✓	✓
	Governance														
32	**Receive minutes and Chair's Report of the Quality Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓		✓	✓
33	**Receive minutes and Chair's Report of the Audit Committee**	Non Executive Director	N/A		✓		✓	✓		✓		✓		✓	✓
34	**BOD Business Cycle 2015/16**	Chair	N/A		✓		✓	✓		✓		✓		✓	✓
35	**Approve BOD Business Cycle 2016/17**	Chair	N/A												✓
36	**Review Risk impacts of items**	Chair/All	N/A		✓		✓	✓		✓		✓		✓	✓
37	**Chair's announcements**	Chair	N/A		✓		✓	✓		✓		✓		✓	✓
38	**Chief Executive announcements**	Chief Executive	N/A		✓		✓	✓		✓		✓		✓	✓

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Progress with implementing the strategic suicide prevention agenda
Agenda ref. no:	16/17/34
Report to (meeting):	Board of Directors – meeting in public
Action required:	Information and noting
Date of meeting:	27/07/2016
Presented by:	Dr Anushta Sivananthan, Medical Director (Executive Lead for Quality)

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
Risk of harm to patients due to ligature points and environmental risks within the inpatient setting	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

The Five Year Forward View called for the Department of Health, Public Health England and NHS England to support all local areas to have multi-agency suicide prevention plans in place as part of major drive to reduce suicides in England by 10% by 2020/21. Regionally, this planning commenced by the Cheshire & Merseyside Suicide Reduction Network (CMSRN) in 2008, which was formed to seek greater co-ordination of responses to and understanding of patterns of suicide. The main output of this group has been the "NO MORE: Zero Suicide" strategy 2015/20 for Cheshire & Merseyside which was published March 2015. CWP has and continues to have an active role in the CMSRN. The purpose of this report is to give an update on the recent work of the CMSRN and how CWP is contributing, both regionally and locally, to the implementation of the strategic suicide prevention agenda.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The CMSRN consists of four components: a Partnership Board; an Operational Group; Local Suicide Prevention Groups; and a Stakeholder Network. CWP has input into all four components. The Partnership Board provides advocacy, expertise and guidance, gaining commitment at a senior level to suicide reduction and enabling integrated provision across organisations. It is developing the strategic vision and ambitions for suicide reduction across the sub-region. The Operational Group implements and develops shared action plans across the sub-region, acting jointly and collaboratively to provide greater efficiency and effectiveness. There are Local Suicide Reduction Groups in West, East and Wirral which mobilise local partners of CWP to implement actions tailored to each particular function but working together to implement the aspirations of a single suicide reduction strategy: "NO MORE: Zero Suicide" strategy (Cheshire & Merseyside Public Health Collaborative, 2015).

Assessment – *analysis and considerations of options and risks*

The "NO MORE: Zero Suicide" strategy and action plan sets out in detail the national and local picture and key drivers for action. CWP is mirroring this strategy as it develops its own strategy and plans, which will be approved by the Board of Directors at the end of the year following full and meaningful consultation. Both strategies intend to achieve a "suicide safer community" (communities that have implemented concerted, strategic approaches to suicide prevention) across Cheshire and Merseyside, establish effective primary care interventions, development of mental health and crisis services, and support for those who are bereaved by suicide. CWP is working closely with the other two mental health trusts in the region to learn through transparency and by working together to improve care. A first successful workshop took place on 28 June 2016. The aim of the workshop was to improve how the regional system learns from harmful incidents, to understand and focus on prevention and responding to fatal self-harm incidents, and to analyse and learn from events that have happened in individual trusts. CWP has a suicide prevention task and finish group, which is overseeing the development of a strategy and its implementation plans. The group is currently reviewing the draft strategy prior to it being shared for consultation. The strategy includes a 3-tier approach to education on suicide prevention. The group has developed an e-learning package (tier 1) for all staff across the Trust. This is currently with Education CWP for review and development into an e-learning platform. Tier 2 will involve face-to-face education for frontline staff. Tier 3 involves a programme to train the trainers through the "Connecting with People" mental health and well-being training model. A major element of the strategy includes the transformation of services, which will incorporate the implementation of the Henry Ford "Perfect Depression Care" model. The suicide prevention task and finish group is arranging a workshop on 8 September 2016 to explore how this can be implemented. The agenda is expected to be circulated across the Trust by the end of July. CWP is also working in partnership in the four component groups in supporting Cheshire & Merseyside to become the first region in the country to be recognised as a "suicide safer community" – there are nine pillars of action which must be met in order to achieve accreditation. These are 1. Leadership/ Steering Committee 2. Background Summary 3. Suicide Prevention Awareness 4. Mental Health and Wellness Promotion 5. Training 6. Suicide Intervention and Ongoing Clinical/ Support Services 7. Suicide Bereavement 8. Evaluation Measures 9. Capacity Building/ Sustainability.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors is asked to **note** progress with implementing strategic suicide prevention approaches across Cheshire & Merseyside and locally within CWP.

Who/ which group has approved this report for receipt at the above meeting?	David Wood, Associate Director of Safe Services
Contributing authors:	Audrey Jones, Head of Clinical Governance David Wood, Associate Director of Safe Services

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Audrey Jones to David Wood	10/07/2016
2	David Wood to Louise Brereton for Board of Directors	11/07/2016

Appendices provided for reference and to give supporting/ contextual information:

Appendix no.	Appendix title
1	http://www.no-more.co.uk/files/no-more-strategy.pdf

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Person Centred Framework Update
Agenda ref. no:	2016/17/35
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	27/07/2016
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
35T	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
This paper introduces the concept of the Person-Centred Framework to the Board of Directors; it provides the context and background to it as well as outlining future plans.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

CWP's recovery strategy comes to an end in September 2016 and, similarly, the involvement strategy also needs to be updated. However, it was felt that whilst the recovery strategy provided a useful framework to progress the personalisation agenda, it was found to be less relevant to some sections of CWP, for example Learning Disabilities, Physical Health and people receiving end of life care. Moreover, the idea is to move away from focusing on a strategy, and instead to introduce a Framework which will be updated so that it remains dynamic, flexible and relevant. The framework will follow a person-centred approach. As far as we are aware, no other trust is implementing such a framework. It will apply equally to everyone, to service users, carers and staff alike. On the 21st June CWP held a one day workshop with staff, service users and carers attending. The draft principles were developed at this workshop for wider discussion and comment. These are available at appendix 1.

Assessment – *analysis and considerations of options and risks*

The aim is for an operational person-centred framework to be launched in January 2017. In preparation for the launch, the Person Centred Principles are being shared widely to make the most of all opportunities. This includes internally at CWP, our partners and other opportunities where we engage with our community.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors is asked to **note** this report and the progress with the development of the framework and is invited to provide feedback on the person centred framework principles as well as sharing them with the CWP community and guiding further opportunities to people to feed back.

Who/ which group has approved this report for receipt at the above meeting?	Liz Matthews, Associate Director of Patient and Carer Experience
Contributing authors:	Liz Matthews, Associate Director of Patient and Carer Experience

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Council of Governors	18/07/2016

Appendices provided for reference and to give supporting/ contextual information:
Provide only necessary detail, do not embed appendices, provide as separate reports

Appendix no.	Appendix title
Appendix 1	Draft Overarching Principles of the Person Centred Framework

2016/17/35 - Appendix 1

Person Centred Framework

On the 21st June 2016, Helen Sanderson Associates facilitated a workshop where people with lived experience and staff from all localities within the CWP came together with the aim of starting a process to create a Person Centred Framework. The goal was to come away with the first set of overarching principles for the Person Centred Framework for wider discussion and comment. This co-production ensured that all services of CWP were represented and they all had a say in what they thought being 'person centred' meant and how it could be embedded within our organisation.

The day was extremely productive and enjoyable with all participants actively taking part and being involved in the decision making.

There were 18 people with lived experience at the workshop with their experience including, but not limited to, substance misuse services, adult mental health services, learning disabilities services and carers.

There were 52 staff members from all localities, specialities and seniorities.

Having this wide range of people attending helped us to come up with some good solid principles to go out to seek wider views and then ready to go into phase 2 of the framework. Phase 2 will then involve another workshop to populate the framework with person centred approaches and tools and to start to think about application, this will be on the 18th October.

The launch event for the framework is scheduled to be held in January 2017.

Feedback

1. Are you in agreement with the overarching Person Centred Framework Principles? Please comment.
2. Are there any areas not covered by these principles which you think need to be included?
   Please comment.
3. Are there any tools or approaches that you think best support the application of the Person Centred Framework Principles? Please comment.

   Please let us know what groups or meetings you have discussed the Principles at.

   Please return your feedback to (email to be confirmed).

Overarching Principles for the Person Centred Framework

1. We are all unique, with our own strengths, needs and aspirations. We know that everyone has different abilities and that we all have something to offer. We will respect and nurture different experiences and viewpoints.

2. We are both willing to learn and are glad to support everyone to live full lives.

3. We believe that mental health and physical health are as important as each other. We will work together to make life the best it can be, remaining positive and hopeful, treating each other fairly consistently.

4. We will celebrate our achievements and learn from everything we do, and we will have the courage to speak up and voice our views. We will always try to improve things to make a lasting difference.

5. We will be honest, realistic and clear about our roles, using language that we all understand.

6. We believe it is important for us to know what matters to each person we meet. We will be adaptable in our approach, working in partnership to provide care which, as far as possible, takes into account each person's preferences.

7. We will encourage and support informed decision-making, giving everyone the choice of when to invite others to act on their behalf. We will empower people to express their preferences and provide support and advice on the different options available, allowing people to make meaningful choices.

8. We will work with everyone's strengths, abilities and those things we may not be so good at, to work together to achieve our goals, taking time to celebrate the good things we do

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Safer Staffing Six Monthly Review
Agenda ref. no:	16/17/36
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	27/07/2016
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership/ Gary Flockhart, Deputy Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
N/A	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*
This report has been produced to provide Board members with details of the findings of the Safer Staffing six month review, covering November 2015 to April 2016, in line with NHS England and the National Quality Board [NQB] requirements. The information in this report is based on meetings with staff members, safer staffing group meetings, desk top review, and analysis of data.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

In January 2014, the Operational Board and Board of Directors received and approved a paper setting out the Trust's current position in relation to ward staffing, vacancies, skill mix and areas for improvement following a comprehensive review led, on behalf of the Board, by the Associate Director of Nursing & Therapies (MH). Since the initial review there have been four, six monthly follow up reviews (including this one). Additionally, monthly reports have been provided to the Board of Directors from June 2014 onwards. In order to comply with NHS England and NQB requirements these reports and the Trust's performance are also published on CWP and NHS Choices websites.

Assessment – *analysis and considerations of options and risks*

The report details findings from actions agreed at the Operational and Trust Boards in January 2016 in relation to:

- Themes arising from ward reviews
- Consistency check with alternative methodology
- Follow up actions relating to deep dive
- Recruitment and retention in relation to original recommendations
- Outcome of care contact time pilot
- National benchmarking
- Widening the consideration of MDT in relation to Safer Staffing
- Context of Safer Staffing within community MH and LD teams
- Safer Staffing Community Physical Health update

The most significant factor emerging in relation to safer staffing does not appear to be in relation to ward establishments but rather the impact of sickness, maternity leave, secondments and restrictions in practice during HR investigations, and, the requirement to backfill or cover these posts. The exceptions to this are Oaktrees and Adelphi which require additional consideration.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Trust Board are asked to approve the recommendations and approach to future work streams as set out in appendix 1: "Six Monthly Safer Staffing Review"

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney
Contributing authors:	Gary Flockhart and Anne Casey

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1 2	Operational Board	July 2016

Appendices provided for reference and to give supporting/ contextual information:

Appendix no.	Appendix title
1 2	Safer Staffing Six Monthly Review Ward fill rates November 2015 to April 2016

16_17_36 Appendix 1

April 2016: Six Monthly Ward Staffing Review

1 Introduction

This report has been produced to provide Board members with details of the findings of the Safer Staffing six month review, covering November 2015 to April 2016, in line with NHS England and the National Quality Board [NQB] requirements. The information in this report is based on meetings with staff members, safer staffing group meetings, desk top review, and analysis of data.

The report summarises key actions completed to date and further action required based on the findings of the review.

1.1 Background to the Ward Nurse staffing review

- In January 2014, the Operational Board and Board of Directors received and approved a paper setting out the Trust's current position in relation to ward staffing, vacancies, skill mix and areas for improvement following a comprehensive review led, on behalf of the Board, by the Associate Director of Nursing & Therapies (MH). In recognition of the on-going requirements related to NHS England Safe Staffing initiatives the Director of Nursing (DoN) has set up a Safer Staffing Group to continue implementation of actions from the review and to take forward the broader pieces of work relating to wider multi-disciplinary teams and to community. The DoN continues to have oversight of ward staffing levels and reports directly to the Board of Directors in line with the NQB requirements.

- Since the initial review there have been four, six monthly follow up reviews (including this one). Additionally, monthly reports have been provided to the Board of Directors from June 2014 onwards. In order to comply with NHS England and NQB requirements these reports and the Trust's performance are also published on CWP and NHS Choices websites.

- In October 2015 the Chief Nursing Officer for England, National Director of Patient Safety NHS England, Chief Inspector of Hospitals and Chairman-Designate NHS Improvement sent a joint letter to Trusts acknowledging that *'recent messages to the system on safe staffing and on the need to intensify efforts to meet the financial challenge have been seen as contradictory'* and encourage Trusts to consider staffing in terms of more than just figures and ratios. CWP adopted this approach from the initial staffing review onwards recommending the continuous improvement of workforce practices alongside considering safe staffing levels in relation to nursing, the wider Multi-Disciplinary Team (MDT) and other professions.

- The April 2016 review was carried out by the Associate Director of Nursing and Therapies (MH and LD) with support from the Head of Performance and Information. The reviewer met with representatives from each ward including General Managers,

Clinical Service Managers, Ward Managers, Modern Matrons, and Allied Health Professionals in order to discuss issues currently impacting on ward staffing on a shift by shift basis and progress made since the last review. The areas discussed covered the range of factors impacting on nursing care challenges and the delivery of high quality care. The ward representatives were challenged on areas of practice and assumptions in order to support the resulting conclusions and recommendations.

- The review team undertook analysis of the information available and have made recommendations to the Board within this report.

2 Report findings

The report consists of a number of reviews and analysis encompassing a comprehensive programme of work in relation to safer staffing progressed since January 2016, comprising the following areas:

2.1 Themes arising from ward reviews
2.2 Consistency check with alternative methodology
2.3 Follow up actions relating to deep dive
2.4 Recruitment and retention in relation to original recommendations
2.5 Outcome of care contact time pilot
2.6 National benchmarking
2.7 Widening the consideration of MDT in relation to Safer Staffing
2.8 Context of Safer Staffing within community MH and LD teams
2.9 Safer Staffing Community Physical Health update

2.1 Themes arising from ward reviews

Methodology
The six-monthly ward staffing review was undertaken in April and May 2016. The review included both qualitative and quantitative data and methodology, following the Telford Model which uses a consultative approach based on professional judgement. To ensure the robustness of this approach, and to reduce bias, quantitative data from a number of sources was used to aid triangulation.

The range of data was considered alongside the National Benchmarking Report 2014, the National Bed Enquiry (2000) and Boardman (2007), NICE guidelines, CQC essential standards and contractual service specifications.

Key findings
It was evident that the clinical teams remain committed to delivering high quality care with the Trust values of the 6Cs being embedded into practice. There was a noticeable positive impact on morale when compared to the initial review 2 years ago and ward teams noted the impact of the investment in nurse staffing numbers agreed by the board in January 2014. Whilst morale was reported to be high a number of themes for consideration arose from the interviews with the ward clinical teams, as detailed below.

2.1.1 Acute wards [Bollin, Beech and Lakefield]

Findings
• The review found that the overall view of the management team is that ward establishments are good and fit for purpose. The management teams are keen to have a flexible approach to manage change to meet clinical need. • The most significant factors emerging in relation to safer staffing, does not appear to be in relation to ward establishments but rather the impact of sickness, maternity leave, secondments and restrictions in practice during HR investigations and the requirement to backfill or cover these posts. The Ward Managers, Clinical Service Managers and General Managers are reporting that the role of the Resource Manager is essential to support the management of these issues and ensuring the clinical visibility of the Ward Managers. • The managers will always respond to change in demand to ensure the safety of patients and staff, which will at times require temporarily increasing numbers on a shift to shift basis. Where extra staff cannot be obtained the wards will work flexibly to cover each other.
Action
• To continue to work with clinical support services to ensure that processes support and enable (and not duplicate) wards in areas including Human Resources, Finance and recruitment and retention. • Actions will be feedback to the Trust Wide Better Use of Information group and progress will be discussed as a standing agenda item on the Safer Staffing group.

2.1.2 Open age acute wards [Adelphi, Juniper and Brackendale]

Findings
• The review found that, similar to the acute and dementia wards, the most significant factors in relation to safer staffing is not in relation to ward establishments but rather the impact of sickness, maternity leave, secondments and restrictions in practice and the requirement to backfill or cover these posts. • The review found that Adelphi and Juniper have a higher proportion of older adults admitted with mobility issues requiring a higher level of care. • In relation to Adelphi ward the view is that the establishment is correct however similar to previous reviews Adelphi continues to use bank staff to increase establishments whilst maintaining higher fill rates. There needs to be an acceptance that in view of the environmental layout of Adelphi this creates an additional challenge in terms of observation of patients who require their physical health needs and mobility issues to be addressed.
Action
• Board are asked to note that Adelphi has consistently higher bank use to support increased observations; inclusive of physical health needs and environmental challenges and should be supported to use additional bank shifts to maintain safer staffing levels where required.

2.1.3 Organic wards [Croft, Cherry and Meadowbank]

Findings
• The review found that again the overall view from the management team was that ward establishments are good and the initial staffing review has had a positive effect for patients, carers and staff. • Cherry ward reported good levels of staff work satisfaction. • Meadowbank ward have no concerns regarding baseline establishment although would like to get to capacity and review banding profile. • Meadowbank and Croft continue to manage sickness with vacancies being an additional factor for Croft.
Action
• Management team in Wirral to review the banding profile on Meadowbank in particular in relation to band 6 and 5 balance.

2.1.4 CAMHS wards [Maple and Pine Lodge]

Findings
• The review found that both CAMHS wards are satisfied with their current establishments. The main factors impacting on staffing are high levels of sickness and maternity leave. Absence is being managed as policy with various levels of management stages in place. The Resource Manager is effectively supporting the Ward Managers to address absence freeing up clinical time for Ward Managers. The move to Ancora House will resolve the environmental issues and isolation of Pine ward.
Action
• The wards will work with colleagues in recruitment to try to reduce the length of time it takes to recruit into vacant posts.

2.1.5 Eating Disorder ward [Oaktrees]

Findings
• During the review Oaktrees reported a change in dependency level since the unit opened. It is now more common for patients to have a BMI below 12 (compared with 14 – 16 previously). The MARSIPAN pathway cover can also impact (when there is a need to send staff to Aintree to support patients requiring acute medical emergency intervention). The Specialist Commissioners currently provide £70k funding for this.
Action
• Due to changes in clinical activity since the initial safer staffing recommendations, the review would recommend a more comprehensive review during the next period. Clinical Service Manager/General Manager to support arranging cover during this period to monitor safety and effectiveness, (including wider use of MDT support). • Clinical and Operational services to review the level of funding available for the

MARSIPAN pathway in line with any increase in demand.

2.1.6 Rehabilitation and Recovery wards [CARS, Limewalk House and Rosewood]

Findings
• The teams reported establishments are good across the three wards. The significant impacts for CARS ward being sickness, vacancies, secondments and difficulty in recruitment. Rosewood is managing long term sickness.
Action
• East locality continue to use wider methods of recruitment including exploring ward based O.T.s as part of the staffing establishment.

2.1.7 PICU Wards [Willow and Brooklands]

Findings
• The review raised no issues with the establishment on Brooklands although the management team report that flexibility is needed to respond to demand due to the nature of the ward, it is at times difficult to fill when they need to increase staff. The review heard that long term sickness can impact. • The team for Willow described pressures on the ward from a clinical point of view, high level observations, and patients with behaviours that challenge. Extra observations requires an increase in staff but there can be difficulties in getting extra staff to cover. • Willow advised that at times PICU beds are blocked and unable to use income generating bed due to pressure on acute beds. • PICU wards reported that staff retention is good which improved quality of patient experience. • No concerns raised in relation to patient safety.
Action
• Link with the inpatient bed review regarding flow of patients from PICU to acute wards. • The PICU operational model has recently been reviewed and changes approved at operational board.

Eastway and Greenways

There is a Trust-wide review currently being undertaken in line with national guidance related to services for people with learning disabilities and therefore no change to the current staffing levels on these wards is recommended at this time.

Impact of Resource Managers

There have been queries raised related to the value added by the role of Resource Managers.

During this review it was reported that the Resource Manager role is highly valued within ward teams across the Trust. Areas of positive impact reported in relation to the role include increase in Ward Manager's visibility, patient and carer engagement and clinical leadership, significant improvements in processes in relation to management of staffing and HR issues.

Ward Manager's reported increased satisfaction with their role feeling Resource Managers were contributing to this.

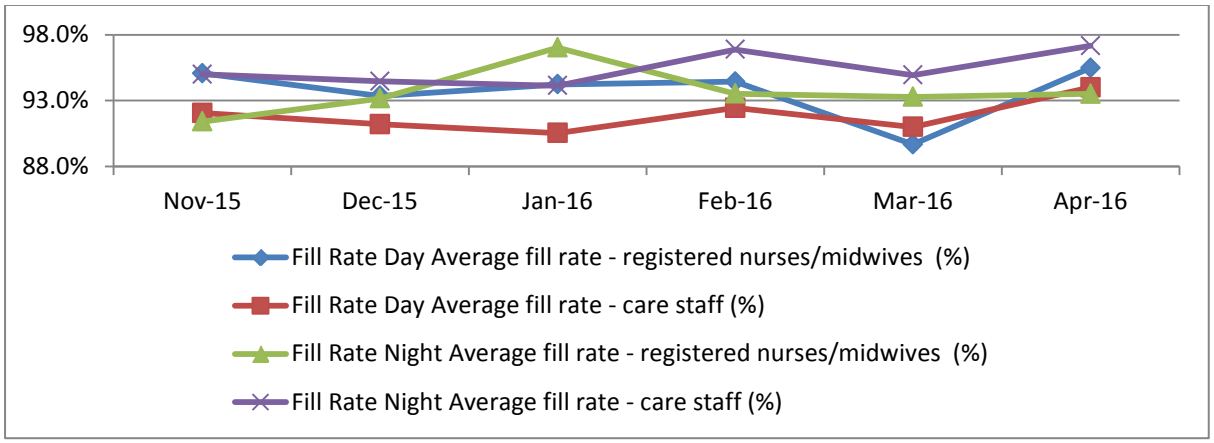
Gym access

A limitation in accessing gyms across the Trust has been reported in the previous ward staffing reviews and remains an issue. This area will be an area for action within the new In-patient Services Improvement Forum.

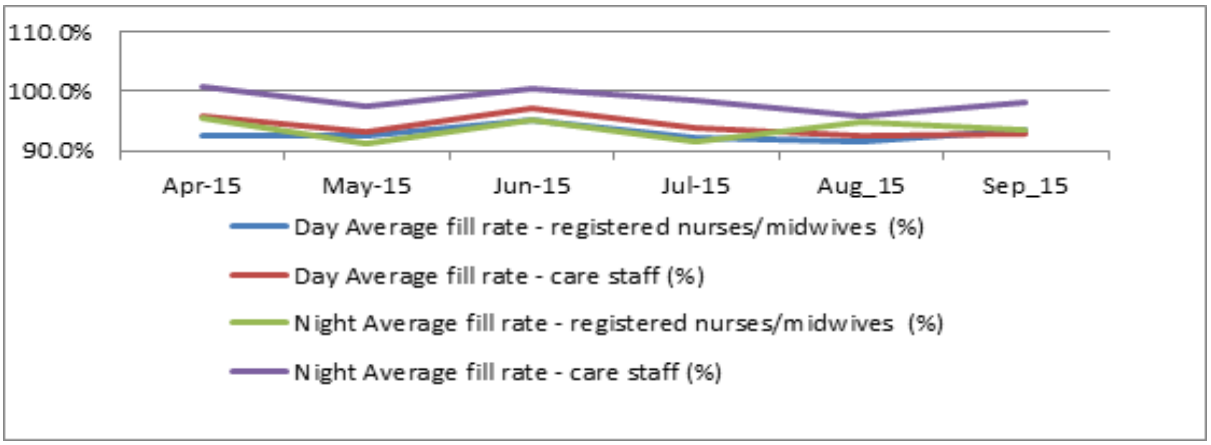
Quality & Safety

This section identifies how wards are maintaining safe staffing levels, the potential impacts and the actions being undertaken currently, alongside future recommended actions, to minimise potential negative impacts.

The CWP reports submitted to UNIFY from November 15 – April 2016 demonstrate that ward staffing actuals have been over 90% of planned staffing as shown in the graph below:



This is broadly comparable with the previous 6 months reporting period [April to September 2015]



Interventions to maintain safe staffing levels

The action taken by the Board in agreeing the safe staffing levels recommendations from the initial review alongside the subsequent work of the programme board and ward teams has had a significant impact in ensuring that CWP wards are safely staffed. On an on-going

basis there are a further four key interventions that contribute to maintaining safe staffing levels. Firstly, effective rostering (see section 2.3), secondly the use of temporary staff to backfill shortfalls, thirdly, actions taken by ward staff to mitigate against the potential impact of unfilled shifts, and the involvement of the Multidisciplinary Team, not just nursing staff.

Temporary staffing - bank and agency use

In order to maintain safe staffing levels, temporary staff continues to be utilised. From October 2015 to March 2016 the following levels were used:

Locality	Total Hours Requested	Total Hours Filled	Bank/Agency Fill Rate (%)	% of Total Planned Hours on Ward covered by Bank/Agency April-Sept 15	WTE filled by Bank	WTE filled by Agency	Total WTE filled
East	48057	37729	79	20	39	0	39
West	40957	29234	71	17	30	0	30
Wirral	36494	27208	75	23	28	0	28
Trustwide	**125508**	**94171**	75	**20**	97	**0**	**97**

Bank use has risen from 94 WTE April-September 2015 to 97 WTE in this current six monthly review. This is compared to 118WTE 12 months prior to the original staffing review. Agency use has been nil in this period. On average over the six months, based on booking reasons used by the wards, approximately 8% of bookings are due to vacancy, 45% due to absence reasons and 47% due to increased workload reasons.

Actions taken by ward staff

Each month Clinical Service Managers report on the actions taken to maintain safe staffing levels on wards. The same themes arise each month and include:

- Nursing staff working additional hours – either by not taking a break or working beyond the end of their shift.
- Nursing staff cross covering wards to maintain safe staffing.
- RN shifts being backfilled by CSWs when RN cover cannot be sourced.
- Ward Managers working in the numbers rather than supernumerary status.
- Multi-disciplinary teams supporting nursing staff in delivering planned care.
- Patient care being prioritised over non-direct care activities such as mandatory training, supervision and appraisal.
- Patient activities being cancelled or shortened due to nurse staffing levels.

The above themes have previously been raised at Operational Board and are consistent with previous reports.

Cross cover between wards: The ward teams acknowledge that it is necessary to balance staffing on a shift by shift basis and appreciate that there will be a level of ‘give and take’

between wards. However if this is happening frequently it can impact on staff morale and also the ability of Ward Managers to develop their teams.

Nurses working additional hours: This remains a concern particularly when working a 12 hour shift pattern. Lack of rest periods and working beyond a 12 hour shift have been found to increase risks to patient safety (Kings College, 2013; HSE, 2012; RCN, 2012) and have a negative impact on staff well-being and retention (Sherward et al, 2005; RCN, 2010). Although staff receive time off in lieu when they work additional hours this does not mitigate against the potential for increased risk during the shift and can contribute to future staffing issues when they reclaim the time. NHS England commissioned a review of shift patterns *'12-hour shifts: Prevalence, views and impact the overall'* and this was published earlier in 2015. The evidence for and against 8 hour and 12 hour shift patterns is inconclusive and although the report suggests that there is cause to challenge assumptions that 12 hour shifts reduce costs without any detrimental effects, ultimately they do not advise against them at this time.

RN shifts backfilled by CSWs: There are occasions when RN shifts are backfilled by CSWs when RN backfill cannot be sourced. Additionally there will be occasions where no backfill is available. The previous six monthly report identified that wards reported there were 218 occasions between April and September 2015 where there was only one RN on duty, in the subsequent 6 months (November – April 2016) this number had reduced significantly to 80 shifts. Where this does occur, wards are able to access a 2nd RN from neighbouring wards for specific procedures that require input from 2 RNs.

Mandatory training, supervision and appraisals cancelled: There are occasions when non direct care activity such as mandatory training, supervision and appraisals are cancelled in order to maintain safe staffing levels on wards. Alternate delivery methods are being explored with Education CWP in order to maximise training delivery.

Patient activities cancelled: In line with previous reviews it is evident patient activities are prioritised by ward teams however there are occasions when patient activities off the ward have to be cancelled or shortened due to nurse staffing levels. All wards reported having proactive measures in place to seek the views of patients during and after admissions. The majority of feedback is reported to be positive and 462 compliments have been registered over the past 6 months. These proactive measures also provide the opportunity to address concerns promptly which again aids patient satisfaction.

Supernumerary Ward Managers: CWP has had supernumerary Ward Managers for a number of years, Ward Managers will however, continue to be part of planned numbers in order to ensure safe staffing when required.

Managing challenges and risks: Whilst wards at times struggle to achieve maximum fill rates, to support the wards to maintain staff staffing the following are in place to identify issues relating to safe staffing levels or risks relating to staffing and to enable escalation and resolution:

- Locality data packs.
- Exception reporting on a monthly basis to Operational Board via key lines of enquiry for localities [KLOE'S].

- Ward escalation process for safe staffing.

2.2 Consistency check with alternative methodology

The Trust has endorsed the use of the Telford Model (professional judgement) to calculate the number of registered and non-registered nurses on inpatient wards to deliver safe staffing levels. In order to consistency check the outcome of this approach it was agreed at the recent Safer Staffing Group meeting to benchmark this outcome with a number of wards by utilising Hurst's Safer Staffing Tool in February 2016.

Findings:
The review undertook a week long exercise to test against the Hurst model. The data examined for each ward included:

- current ward MDT establishments
- skill mix ratios
- bank usage
- sickness
- incidents
- uptake of education
- supervision/ appraisal compliance

The review indicated that there may be a requirement to increase establishments, however due to the significant limitations this is inconclusive.

	Beds	Original Telford (and current establishment)									Oct 2015 Telford recommendations									Mar 2016 Hurst						
		M-F days		Sat-Sun days		Nights		RN WTE	CSW WTE	Total	M-F days		Sat-Sun days		Nights		RN WTE	CSW WTE	Total	Days		Nights		RN WTE	CSW WTE	Total
		RN	CSW	RN	CSW	RN	CSW				RN	CSW	RN	CSW	RN	CSW				Total		Total				
Adelphi	23	4	2	3	3	2	2.4	14.0	12.1	26.1	4	3	4	3	2	3.8	15.5	17.6	33.1	8.2		4.2		18.6	15.9	34.5
Brackendale	20	3	3	3	3	2	2.5	12.9	14.2	27.1	3	3	3	3	2	2.5	12.9	14.2	27.1	7.5		3.5		14.1	16.6	30.7
Juniper	22	3	3	3	3	2	2	12.5	12.5	25.0	4.1	3	4	3	2	2	15.8	12.9	28.7	8.0		4.0		17.1	17.1	34.2
Eastway	10	3	2	3	2	2	1	12.9	7.8	20.7	3	2	3	2	2	1	12.9	7.8	20.7	6.4		2.4		14.8	9.9	24.7

Hurst tool limitations:

- No differentiation between weekends and weekdays
- No capture of additional roles such as activity co-ordinators
- No clarity on day-night split calculation
- No split given re RN:CSW in shift by shift outcome
- No longitudinal comparison regarding clinical activity and need

As identified above, these limitations means it is not possible to make any guiding assumptions or suggest consistency or generalisability of findings.

However, as per previous methodologies used Adelphi has again been indicated as an area which may require an increased establishment. Based on feedback from the ward management team it was felt that rather than directly increasing establishment at the moment, the establishment should remain "as is" but with a clear understanding and acceptance that Adelphi will on a shift to shift basis be required to use bank staff to support high levels of observation in relation to physical and mental health needs. Adelphi has also previously been flagged as an area which finds it difficult to achieve its safer staffing levels.

However from January to April 2016 Adelphi has consistently achieved registered and care staff fill rates in excess of 90% (the exception being care staff reported as 85.4% in March (see appendix 2)).

2.3 Follow up actions relating to deep dive

The previous 'deep dive' analysis of e-rostering and associated links with bank usage and sickness absence suggested that there was scope for improvement in rostering practices. Support People Services worked with localities to further investigate the themes emerging from the deep dive to examine effective and efficient use of the roster and take remedial actions where necessary.

Update:
The recommendations from the ward deep dive exercises were to reinvigorate rostering practice via improved software, agreed standardised operating procedures and a revised overarching policy. In June 2016, a successful business case was developed for investment in the e-rostering product (Healthroster) and the procurement process has recently been completed. It is hoped that implementation of the new software will begin in August 2016. This will take approximately 12 weeks. During this time, focus groups for stakeholders will be established to agree the revised processes and policy in order to support the new product and maximise rostering effectiveness in CWP. A recent audit by MIAA has identified issues identical to those found as part of the deep dive exercise. Of particular concern was how 'time owing' is managed by services which will necessarily be one of the key focusses of this work. People Information have already commenced an audit with the rostered units on their time owing balances in advance of migration to the new software to establish the current position; this will be completed before implementation commences.

2.4 Recruitment and retention in relation to original recommendations

It was recognised in previous reports that it was difficult to fully realise the benefits of increased staffing establishments when wards still had significant vacancies. In particular due to the number of newly qualified staff requiring preceptorship and the need to balance this against the number of experienced staff.

Update:
Since the initial review undertaken in December 2013, an ongoing rolling recruitment programme has been in place. The table below indicates the establishments as at April 2016 and demonstrates significant improvement since the previous six month review. The information is taken from the People Information 'Truth on a page ward profile':

Trust Wards	Current WTE [budgeted establishment]	Current WTE [Staff in post]	Staffing differential	Current WTE in recruitment *
Registered Nurses	319.42	304.03	15.39	28.76

Clinical Support Workers	316.57	301.65	14.92	9

This figure includes posts out to advert and candidates waiting to start pending checks

2.5 Care Contact Time Summary

In line with the NQB and NHS England requirements the trust examined Care Contact Time during a one week period in November 2015. Four wards were included in the study which followed the same format as the 'Activity Follows' survey undertaken in 2012 across all adult and older people in-patient wards within the trust. The wards included in November 2015 were Cherry (organic), Croft (organic), Saddlebridge (low secure) and Eastway (learning disabilities). All Ward Manager (WM) and Clinical Leads shifts were included in the data capture. One band 5 Registered Nurse and one band 3 and/or 4 Non-Registered Nurse completed the data capture on each day and night shift during the same period.

Summary of findings:

- There was a high level of consistency across the top 4 activities for all staff groups.
- Administration featured in the top 3 activities for all Ward Managers and in the top 4 for all Clinical Leads and Staff Nurses, although the time spent on administration was slightly lower than in 2012 (from 27% to 24% for Ward Managers and from 17% to 11% for Clinical Leads/Staff Nurses).
- Personal and people development was in the top 4 activities for 3 of the 4 Ward Managers – this activity showed an increase of 8% on average from 2012 and includes activities such as supervisions, appraisals, continued personal development.
- Time spent on dealing with staffing issues had reduced significantly for all Ward Managers, Clinical Leads and Staff Nurses.
- Patient/carer contact/interventions and carenotes input were in the top 4 activities for band 5 and 6 nurses across all 4 wards on both day and night shifts.
- Patient/carer contact/interventions and activities supporting other services (eg mental health act and safeguarding) were in the top 4 activities for non-registered staff on all 4 wards on day shifts. Patient/carer contact/interventions remained broadly the same amount of as 2012 activity (40%) however activities supporting other services had increased from 2% to 11%.
- Patient observation activity had reduced for non-registered staff, on days, from 42% in 2012 to 28% in 2015.
- On nights patient observations and patient/carer contact/interventions were in the top 3 activities for all 4 wards with an average of 43% and 28% respectively whereas in 2012 they were the top 2 activities at 48% and 32% respectively.
- Resource Managers appear to have impacted positively time spent on administration and dealing with staffing issues.

However time spent on administration remains high for registered staff and the Safer Staffing Group have identified this as an area for action.

Action: There were again limitations into the generalisability of the care contact time findings; moving forward the plan is to revise the data capturing process from paper lead to

an electronic system with the intention of streamlining the process and supporting data analysis.

2.6 National benchmarking

Through support from Knowledge Management Services the 6 Monthly Safer Staffing reports from a number of local and wider NHS Trusts were retrieved with the ambition of profiling either hours required by wards or base line staffing figures against those of CWPs inpatient units.

Benchmarking ward establishments and safer staffing figures has proved to be challenging with no clear outcomes in relation to either comparison or recommendations, due to a number of factors;

- Varying methods of reporting; percentage vs hours.
- No specific data to allow (even a proxy) comparison to compare wards (e.g. ward type, number of beds).
- No indication of extent of services which offer alternative to admission or in-reach into wards.
- No reporting of wider MDT input and impact on staffing.
- No locality demographic information .

Action: To continue to engage in ongoing work across the wider MH and LD leads network in relation to safer staffing. To continue to support ongoing internal work in relation to the inpatient service and community reviews (see 2.8 below).

2.7 Widening the consideration of MDT in relation to Safer Staffing

Following on from the original ward staffing review it was recommended that a similar review in relation to the Occupational Therapy (O.T) inpatient services. This aligns with current national acknowledgment that nurse staffing does not support wards independently and that the Multidisciplinary Team (MDT) plays a significant role in ensuring that wards are safely staffed.

Summary of findings from In-patient O.T reviews
The O.T reviews were undertaken across the three localities against the following guiding principles:

1. Service users on inpatient units will have Occupational Therapy assessment in a timely manner.
2. Service users will have access to Occupational Therapy treatment to support their recovery.
3. The acute care pathway will serve as a benchmark for good standards of practice. For example, the pathway details standards for assessment and initial contact.

4. Service users across the Trust should have equitable access to service. For example, access to Occupational Therapy should not be affected by postcode or which day of the week a person is admitted to hospital.
5. Occupational Therapists will work as an integrated member of the Multidisciplinary Team and aim to provide continuity of care.
6. Occupational Therapy services should adopt flexible working to meet local needs and best utilise resources available.
7. Occupational Therapy services will be run in a sustainable way to support staff retention and wellbeing, and ensure quality is maintained.

Following the completion of the reviews there are clear variations across the three localities in both the operational model of working for O.T.s and the teams whole time equivalent establishments.

- Central and East have recently piloted a 7 day working model (9am – 5pm) focussing on assessment at weekends.

- West currently work extended hours in most areas. This has been achieved Monday – Friday, by using the existing staffing levels in a more effective and efficient manner across the hours of 7.30am – 7pm depending on service user needs.

- Wirral currently provide O.T service provision 8.30 – 4.30 Monday – Friday, in addition staff work late twice a month on PICU and once a month on other wards to provide an evening social, time taken back as time in lieu.

The 3 models all have clear benefits and challenges based on availability of the team to fulfil all aspects in relation to the guiding principles (as detailed above) due to the challenges of capacity versus demand and variance in whole time equivalents establishments.

Recommendation: The reviews were led by the lead O.T.s in each locality and full summary reports were produced which require more in depth presentation and discussion at Operational Board to explore options in relation to the preferred working model which best meets the needs of service users.

2.8 Context of Safer Staffing within community MH and LD teams

The focus of safer staffing to date has been on mental health and learning disability inpatient areas. There is a growing recognition that this needs to expand into community teams.

Update:
Following a trust wide Bed Review a further review is being undertaken in relation to bed occupancy from a clinical perspective. The review aims to explore the following areas:

- Whether there is effective input from the Community Mental Health Teams (CMHT) and Home Treatment Teams (HTT) prior to admission and whether additional interventions can be put into place to avoid admission for certain individuals.

- Whether early warning signs are picked up on early enough and whether the Crisis Care Plan/ Contingency plans are robust enough to be of assistance to a service user in managing deterioration in their mental health.
- Whether the systems and processes in place within CMHT's, HTT and the inpatient areas are effective in managing service users' individual needs.
- Whether the availability of placements or the application/ funding process extends a service users admission to inpatient services.
- Whether there are gaps in current service provision which extend the service users length of stay.

This piece of work will be undertaken in all three localities during June, July and August with the findings and recommendations being reported to the Inpatient Redesign Project Group.

Transforming Care Agenda
There is a trust wide project aimed at transforming services for people of all ages with a learning disability and / or autism who display behaviour that challenges, including those with a mental health condition, in line with *Building the Right Support* to implement the national service model by March 2019 by reducing inpatient beds and realigning funding to community-based support. Part of the review will include ensuring effective staffing.

2.9 Safer Staffing Community Physical Health update

As an adjunct to the work being undertaken within inpatient mental health services, work is underway in Community Physical Health Services to:

- Understand the current demand, capacity, acuity and risks of the current community workload.
- develop a robust framework which provides assurance that these elements are reflected in staffing establishment numbers, and that levels of safe staffing are monitored in line with the in- patient services reports.
- In partnership with West Cheshire Clinical Commissioning Group adopt a tool which can support the commissioning of community nursing services and strategic workforce planning.

In January 2016 a revised predictive capacity management tool was implemented to support the safe management of community nursing caseloads, in addition a guidance document for managing community nursing caseloads has been developed and is currently being consulted upon with frontline staff and managers. An early warning system to support appropriate escalation is in development supported by safe services.

The service is currently undertaking a "deep dive" into the integrated teams, which will give a historical and current contextual overview, describe services and, where possible, benchmark them against National and Local metrics, it will also summarise the feedback and analyse the themes from the staff.

This work will collectively begin to inform the project group in the potential resource allocation required to develop a caseload staffing establishment framework which also takes into account a variety of impacting factors for example; demographics, current cultural use of services, and service specification criteria. Existing research offers suggestions of

overarching ideas about possible approaches but do not offer detailed frameworks, models, or tools that could readily be employed.

3 Conclusion and Recommendations

The review team would like to acknowledge the evident commitment within clinical services to ensure the ongoing provision of high quality care and in their work supporting the safer staffing six monthly review. The board are respectfully requested to consider and approve the following recommendations:

- To note the content of the report and the key recommendation that ward establishments should be sustained at current levels to maintain safer staffing.

- To continue to progress relevant workstreams as detailed within the Safer Staffing Working Group in particular in relation to:

    - The next six monthly safer staffing review.
    - Expand the work already under way in relation to mental health, learning disability, physical health and community services.
    - Working closely with support services to support wards in relation to human resource processes.
    - Linking in with national work programmes in relation to safer staffing.

- The full occupational therapy reviews undertaken across the three localities should be presented and discussed at operational board.

- Due to changes in the clinical profile of patients on Oaktrees a further more detailed review should be progressed by operational and clinical services including consideration of the MARSIPAN pathway.

- There should be recognition and acceptance that due to environmental constraints and high levels of observations required to meet physical and mental health needs, Adelphi requires to use varying degrees of bank use to ensure ongoing safer staffing requirements.

4 References

DH (2014) '*Safer Staffing: a guide to care contact time'*: London

NHS England (2015) *'12-hour shifts: Prevalence, views and impact the overall':* London

NICE (2014) *'Safe staffing for nursing in adult inpatient wards in acute hospitals'* http://www.nice.org.uk/guidance/sg1

Appendix 2

Nov 15 – Apr 16	Locality	Ward	Day				Night				Fill Rate			
			Registered		Care Staff		Registered		Care Staff		Day		Night	
			Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)
Nov	East	Adelphi	1288	1184.5	1330	1267	738.75	589.25	1136	1069.5	92.0%	95.3%	79.8%	94.1%
Dec	East	Adelphi	1343	1284.5	1575.5	1294.5	740	733	1380	1196	95.6%	82.2%	99.1%	86.7%
Jan	East	Adelphi	1379.45	1322.5	1386.5	1289.5	849.5	849.5	1289.5	1220.5	95.9%	93.0%	100.0%	94.6%
Feb	East	Adelphi	1259.5	1151.5	1164.3	1134.3	678.5	667	1104	1087	91.4%	97.4%	98.3%	98.5%
Mar	East	Adelphi	1288.5	1184.2	1403.5	1199	736	736	1166.5	1098.5	91.9%	85.4%	100.0%	94.2%
Apr	East	Adelphi	1378.54	1345.5	1294	1204.5	759	747.5	1276.5	1219.5	97.6%	93.1%	98.5%	95.5%
Nov	East	Alderley Unit	952.5	960	1323	1286	598	506	839.5	866.5	100.8%	97.2%	84.6%	103.2%
Dec	East	Alderley Unit	920.5	917	1354	1179.5	701.5	598.5	713	793	99.6%	87.1%	85.3%	111.2%
Jan	East	Alderley Unit	827	830	1353	1321	713	690	713	724.5	100.4%	97.6%	96.8%	101.6%
Feb	East	Alderley Unit	772.5	739	1298	1269	632.5	589.5	701.5	738	95.7%	97.8%	93.2%	105.2%
Mar	East	Alderley Unit	829	819.5	1414.5	1449	690	678.5	736	759	98.9%	102.4%	98.3%	103.1%
Apr	East	Alderley Unit	891	844.5	1322.5	1283	690	604	690	776.5	94.8%	97.0%	87.5%	112.5%
Nov	East	Bollin	1227	1214.5	1482.5	1307.5	724.5	667	1449	1391.5	99.0%	88.2%	92.1%	96.0%
Dec	East	Bollin	1153	1058	1555	1531.5	752	706	1270	1131.5	91.8%	98.5%	93.9%	89.1%
Jan	East	Bollin	1448	1428	1518	1304	782	724.5	1327	1138.5	98.6%	85.9%	92.6%	85.8%
Feb	East	Bollin	1269.5	1263.5	1358.5	1181	721.5	710	1207.5	1096.5	99.5%	86.9%	98.4%	90.8%
Mar	East	Bollin	1396.5	1366.5	1273	1238.5	763.5	763.5	1391.5	1394.5	97.9%	97.3%	100.0%	100.2%
Apr	East	Bollin	1312.5	1279.75	1210.5	1212	793.5	772	1297.5	1263	97.5%	100.1%	97.3%	97.3%
Nov	East	CARS	889	837	1426.5	1345	701.5	661.03	713	676.5	94.2%	94.3%	94.2%	94.9%
Dec	East	CARS	886.5	844	1246	1231	701.5	678.5	724.5	616.53	95.2%	98.8%	96.7%	85.1%
Jan	East	CARS	864	820.5	1304.5	1292.5	701.5	665	701.5	644	95.0%	99.1%	94.8%	91.8%
Feb	East	CARS	900.5	888.5	1081.5	1059	656	623	691	677.5	98.7%	97.9%	95.0%	98.0%
Mar	East	CARS	889	872	1337.5	1238.5	690	657.5	724.5	674.5	98.1%	92.6%	95.3%	93.1%
Apr	East	CARS	929	913	1207.5	1150	690	681.5	717	612.25	98.3%	95.2%	98.8%	85.4%
Nov	East	Croft	1304.25	1304.75	1853	1414	805	781	1871.5	1517.5	100.0%	76.3%	97.0%	81.1%
Dec	East	Croft	1462.5	1396	1662.5	1323.8	770.5	770.5	1762	1409.5	95.5%	79.6%	100.0%	80.0%
Jan	East	Croft	1663.25	1490.5	1478.95	1204.5	778	800.25	1740.5	1361	89.6%	81.4%	102.9%	78.2%
Feb	East	Croft	1280	1317.7	1649	1185	678.5	697.5	1720.5	1517	102.9%	71.9%	102.8%	88.2%
Mar	East	Croft	1302.1	1368.41	1709	1108.3	730	698.5	1748	1539.7	105.1%	64.9%	95.7%	88.1%
Apr	East	Croft	1448.5	1436.5	1421.5	1244.5	770.5	738.5	1656	1481	99.2%	87.5%	95.8%	89.4%
Nov	East	Greenways	1260.5	1169.5	1872	1682	690	598	724.5	774	92.8%	89.9%	86.7%	106.8%
Dec	East	Greenways	1208	1063.5	1806	1577.25	713	655.5	713	747.5	88.0%	87.3%	91.9%	104.8%
Jan	East	Greenways	1279.5	1225.5	1932	1768.5	713	690	736	717.5	95.8%	91.5%	96.8%	97.5%
Feb	East	Greenways	1216.5	1182	1776	1526.5	667	483	667	836	97.2%	86.0%	72.4%	125.3%
Mar	East	Greenways	1297.5	1282	1807.5	1613.5	713	609.5	736	775	98.8%	89.3%	85.5%	105.3%
Apr	East	Greenways	1870	1594.5	1109	1444.5	690	667	690	690	85.3%	130.3%	96.7%	100.0%
Nov	East	LimeWalk	1067.5	1042	1137	1092	664	605	742	693.5	97.6%	96.0%	91.1%	93.5%
Dec	East	LimeWalk	1003	991.5	1155	1088	694	676	747.5	656.5	98.9%	94.2%	97.4%	87.8%
Jan	East	LimeWalk	1167.5	1160.5	1066	1004	713	706	725	694.5	99.4%	94.2%	99.0%	95.8%
Feb	East	LimeWalk	900.5	888.5	1081.5	1059	656	623	691	677.5	98.7%	97.9%	95.0%	98.0%
Mar	East	LimeWalk	1123.5	1106	1097	981.95	690	601.5	736	699.5	98.4%	89.5%	87.2%	95.0%
Apr	East	LimeWalk	1088.5	1034	1130.25	986.75	655.5	610.5	752	671.5	95.0%	87.3%	93.1%	89.3%
Nov	East	Saddlebridge	877	888.5	1297	1280	641.5	607	740.5	768	101.3%	98.7%	94.6%	103.7%
Dec	East	Saddlebridge	871.5	871.5	1437.5	1403	701.5	690	729	740.5	100.0%	97.6%	98.4%	101.6%
Jan	East	Saddlebridge	855.5	834.5	1447.5	1404	644	644	793.5	782	97.5%	97.0%	100.0%	98.6%
Feb	East	Saddlebridge	804.5	793	1395.5	1389.5	630	630	825.5	814.5	98.6%	99.6%	100.0%	98.7%
Mar	East	Saddlebridge	835	824.75	1393	1393	635	623.5	790	794	98.8%	100.0%	98.2%	100.5%
Apr	East	Saddlebridge	844	856	1618.5	1618.5	654	642.5	1043.5	1055	101.4%	100.0%	98.2%	101.1%

Nov 15 – Apr 16	Locality	Ward	Day				Night				Fill Rate			
			Registered		Care Staff		Registered		Care Staff		Day		Night	
			Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)
Nov	West	Beech	1389.5	1225	1138.5	1065	678.5	680.5	701.5	680.5	88.2%	93.5%	100.3%	97.0%
Dec	West	Beech	1454	1346.5	1139.5	1045	770.5	661	678.5	663	92.6%	91.7%	85.8%	97.7%
Jan	West	Beech	1378	1222	1167	1050	724.5	724.5	724.5	724.5	88.7%	90.0%	100.0%	100.0%
Feb	West	Beech	1366.5	1134.5	1069.5	997.5	667	667	747.5	724.5	83.0%	93.3%	100.0%	96.9%
Mar	West	Beech	1477.5	1180.5	1238.5	1102	699.5	676.5	874	791.5	79.9%	89.0%	96.7%	90.6%
Apr	West	Beech	1401.5	1286	1081	1014	701.5	667	724.5	724.5	91.8%	93.8%	95.1%	100.0%
Nov	West	Cherry	1255	1169.5	1104	931.5	736	552.04	1058	885.5	93.2%	84.4%	75.0%	83.7%
Dec	West	Cherry	1104.06	1122.5	1081	1019.5	713	678.5	989	1000.5	101.7%	94.3%	95.2%	101.2%
Jan	West	Cherry	1148	1126.25	1202	1134.5	713	678.5	1023.5	966	98.1%	94.4%	95.2%	94.4%
Feb	West	Cherry	879	810	1215	1184.5	724.5	563.5	920	908.5	92.2%	97.5%	77.8%	98.8%
Mar	West	Cherry	1224.5	1167.5	937.5	893.5	747.5	637	1035	922.3	95.3%	95.3%	85.2%	89.1%
Apr	West	Cherry	1204.5	1158.5	977.5	943	713	632.5	989	924.5	96.2%	96.5%	88.7%	93.5%
Nov	West	Eastway	974	871	1345	1291.5	644	575	805	805	89.4%	96.0%	89.3%	100.0%
Dec	West	Eastway	894	894	1400.5	1335	678.5	632.5	756.5	745	100.0%	95.3%	93.2%	98.5%
Jan	West	Eastway	857	798	1231	1196.5	586.5	540.5	793.5	793.5	93.1%	97.2%	92.2%	100.0%
Feb	West	Eastway	694.5	684.5	1258.5	1201	586.5	552	736	701.5	98.6%	95.4%	94.1%	95.3%
Mar	West	Eastway	861	831.5	1252.5	1149	633	621.5	754	702.5	96.6%	91.7%	98.2%	93.2%
Apr	West	Eastway	1126.25	1126.25	868.5	822.5	531	531	809	809	100.0%	94.7%	100.0%	100.0%
Nov	West	Juniper	1485	1445.3	1035	1035	747.5	736	839.5	828	97.3%	100.0%	98.5%	98.6%
Dec	West	Juniper	1412.5	1334.5	1023.5	922.5	724.5	674	724.5	718.5	94.5%	90.1%	93.0%	99.2%
Jan	West	Juniper	1530.5	1375.5	1058	918	713	713	722	669	89.9%	86.8%	100.0%	92.7%
Feb	West	Juniper	1416.5	1266	1000.5	918	713	701.5	722	609.5	89.4%	91.8%	98.4%	84.4%
Mar	West	Juniper	1578.5	1392.6	1150	885.5	782	770.5	793.5	655.5	88.2%	77.0%	98.5%	82.6%
Apr	West	Juniper	1503	1406.5	1031.5	901.5	655.5	655.5	724.5	682	93.6%	87.4%	100.0%	94.1%
Nov	West	Maple	1162	932	1368.5	1219	690	655.5	701.5	736	80.2%	89.1%	95.0%	104.9%
Dec	West	Maple	1170	894	1345.5	1299.5	724.5	621	713	759	76.4%	96.6%	85.7%	106.5%
Jan	West	Maple	1235	1212	1575.5	1311	736	678.5	1058	1058	98.1%	83.2%	92.2%	100.0%
Feb	West	Maple	1144	983	1357	1230.5	667	471.5	885.5	977.5	85.9%	90.7%	70.7%	110.4%
Mar	West	Maple	1144	880	1403	1230.5	724.5	552	954.5	839.5	76.9%	87.7%	76.2%	88.0%
Apr	West	Maple	1087.5	911	1403.2	1196	690	494.5	1046.5	862.5	83.8%	85.2%	71.7%	82.4%
Nov	West	Pine	1100.5	1001	1012	908.5	690	506	690	713	91.0%	89.8%	73.3%	103.3%
Dec	West	Pine	1109	787	1242	1150	724.5	598	897	862.5	71.0%	92.6%	82.5%	96.2%
Jan	West	Pine	1158	1146.5	1104	966	701.5	644	851	770.5	99.0%	87.5%	91.8%	90.5%
Feb	West	Pine	1040.5	1006	1046.5	908.5	667	609.5	770.5	782	96.7%	86.8%	91.4%	101.5%
Mar	West	Pine	1166	887.1	1069.5	1142.5	713	632.5	966	943	76.1%	106.8%	88.7%	97.6%
Apr	West	Pine	1112	1001	1035	1127	690	471.5	816.5	1035	90.0%	108.9%	68.3%	126.8%
Nov	West	Rosewood	1284.5	1172.5	1402.5	1266.5	448.5	402.5	701.5	669	91.3%	90.3%	89.7%	95.4%
Dec	West	Rosewood	981.5	958.5	1563	1471	552	494.5	747.5	724.5	97.7%	94.1%	89.6%	96.9%
Jan	West	Rosewood	1024	978	1276.5	1081	402.5	402.5	966	839.5	95.5%	84.7%	100.0%	86.9%
Feb	West	Rosewood	888	888	1233.5	1176	379.5	379.5	782	747.5	100.0%	95.3%	100.0%	95.6%
Mar	West	Rosewood	1030.5	962.5	1284.5	1223	488.5	442.5	793.5	770.5	93.4%	95.2%	90.6%	97.1%
Apr	West	Rosewood	943	924.5	1269.5	1200.5	471.5	448.5	759	701.5	98.0%	94.6%	95.1%	92.4%
Nov	West	Willow	965	931.75	1035	1046.5	736	736	770.5	747.5	96.6%	101.1%	100.0%	97.0%
Dec	West	Willow	990.5	1000.5	993	924	713	690	724.5	724.5	101.0%	93.1%	96.8%	100.0%
Jan	West	Willow	1046	1062.5	1123	1068	759	754	877.5	870	101.6%	95.1%	99.3%	99.1%
Feb	West	Willow	877.5	864.5	1007.1	992	678.5	678.5	770.5	761.5	98.5%	98.5%	100.0%	98.8%
Mar	West	Willow	972.5	946.5	1184.5	1161.5	747.5	713	966	977.5	97.3%	98.1%	95.4%	101.2%
Apr	West	Willow	999	984	1012	1012	667	632.5	839.5	862.5	98.5%	100.0%	94.8%	102.7%

Month and Year of Data	Locality	Ward	Day				Night				Fill Rate			
			Registered		Care Staff		Registered		Care Staff		Day		Night	
			Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)
Nov	Wirral	Brackendale	1056.5	1033.5	1025.5	945	690	690	690	667	97.8%	92.2%	100.0%	96.7%
Dec	Wirral	Brackendale	1087	1053.5	921	898	701.5	667	724.5	724.5	96.9%	97.5%	95.1%	100.0%
Jan	Wirral	Brackendale	1127	1147	902.5	799	701.5	678.5	736	736	101.8%	88.5%	96.7%	100.0%
Feb	Wirral	Brackendale	1016.5	1134.5	859.5	813.5	667	667	690	667	111.6%	94.6%	100.0%	96.7%
Mar	Wirral	Brackendale	1060.5	988	920	793.5	724.5	719	713	690	93.2%	86.3%	99.2%	96.8%
Apr	Wirral	Brackendale	1071.5	1027.5	926	891.5	701.5	690	690	690	95.9%	96.3%	98.4%	100.0%
Nov	Wirral	Brooklands	1012.25	1015.4	1477	1477	640.5	604.5	1196	1196	100.3%	100.0%	94.4%	100.0%
Dec	Wirral	Brooklands	1160	1009	1370	1189.5	736	713	1035	989	87.0%	86.8%	96.9%	95.6%
Jan	Wirral	Brooklands	1272	960.35	1619	1474.5	724.5	689	1265	1208.5	75.5%	91.1%	95.1%	95.5%
Feb	Wirral	Brooklands	1106	856.5	1524.5	1413	667	682.5	1298	1211	77.4%	92.7%	102.3%	93.3%
Mar	Wirral	Brooklands	1232.5	941.5	1416	1326.5	717	625.5	1426	1380.5	76.4%	93.7%	87.2%	96.8%
Apr	Wirral	Brooklands	930.5	815	1305.5	1344	713	638.5	808	837.5	87.6%	102.9%	89.6%	103.7%
Nov	Wirral	Lakefield	1040	1051	1104	977.5	690	687	690	678.5	101.1%	88.5%	99.6%	98.3%
Dec	Wirral	Lakefield	1177.5	1096	1203.5	1031	713	678.5	729	671.5	93.1%	85.7%	95.2%	92.1%
Jan	Wirral	Lakefield	1124.5	1053.5	1206.5	1046	713	690	632.5	632.5	93.7%	86.7%	96.8%	100.0%
Feb	Wirral	Lakefield	804.5	793	1395.5	1389.5	630	630	825.5	814.5	98.6%	99.6%	100.0%	98.7%
Mar	Wirral	Lakefield	1153.25	1034.5	1076	972.5	713	678.5	713	747.6	89.7%	90.4%	95.2%	104.9%
Apr	Wirral	Lakefield	1271.75	1077.25	1108.5	971	713	724.5	713	655.5	84.7%	87.6%	101.6%	91.9%
Nov	Wirral	Meadowbank	1099.5	1080.5	2248	2064	619.5	510.5	2096	1889	98.3%	91.8%	82.4%	90.1%
Dec	Wirral	Meadowbank	1141	1112.5	2129.5	2072	713	609.5	1752	1682	97.5%	97.3%	85.5%	96.0%
Jan	Wirral	Meadowbank	1090	1034.5	2285.5	2189	713	678.5	1829	1794.5	94.9%	95.8%	95.2%	98.1%
Feb	Wirral	Meadowbank	1048	897	2356	2216.5	586.5	458	1712	1553	85.6%	94.1%	78.1%	90.7%
Mar	Wirral	Meadowbank	1041	1028.5	2279.5	2193.5	724.5	644	1478	1398.53	98.8%	96.2%	88.9%	94.6%
Apr	Wirral	Meadowbank	1916.5	1832.8	824	1690.3	563.5	540.5	1449	1380	95.6%	205.1%	95.9%	95.2%
Nov	Wirral	Oaktrees	1351	1326.5	1519.5	1369	678.5	678.5	963	858.5	98.2%	90.1%	100.0%	89.1%
Dec	Wirral	Oaktrees	1303.5	1213.5	1492	1185.5	735	723.5	605	501.5	93.1%	79.5%	98.4%	82.9%
Jan	Wirral	Oaktrees	1354	1167	1455	1157	713	713	437	425.5	86.2%	79.5%	100.0%	97.4%
Feb	Wirral	Oaktrees	1200	1126.5	1310.5	1120.5	667	655.5	345	322	93.9%	85.5%	98.3%	93.3%
Mar	Wirral	Oaktrees	1335	1185.5	1419.5	1256.5	713	713	356.5	345	88.8%	88.5%	100.0%	96.8%
Apr	Wirral	Oaktrees	1388	1325	1459.5	1315	690	678.5	356.5	345	95.5%	90.1%	98.3%	96.8%

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Ward Daily Staffing Levels May and June 2016
Agenda ref. no:	16/17/37
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	27/07/2016
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	No
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
Click here to enter text.	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
Click here to enter text.	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

This report details the ward daily staffing levels during the month of May and June 2016 following the submission of the planned and actual hours of both registered nurses (RN) and clinical support workers (CSWs) to UNIFY (appendix 1 and 2). The themes arising within these monthly submissions continue to mirror those that have arisen previously. These themes identify how patient safety is being maintained on a shift by shift basis.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The monthly reporting of daily staffing levels is a requirement of NHS England and the National Quality Board in order to appraise the Board and the public of staffing levels within in-patient units. CWP undertook a comprehensive review of ward staffing levels between Oct and Dec 2013 with 6 monthly follow up reviews, the most recent of which has been submitted to Operations Board in July 2016 and to Board of Directors in July 2016. A number of recommendations were made within the latest six monthly report including consistency checking, national benchmarking, and widening the consideration of the MDT role within safer staffing. These recommendations are currently being followed through and will be reported on in the next 6 monthly report.

Assessment – *analysis and considerations of options and risks*

During May 2016 the trust achieved staffing levels of 94.9% for registered nurses and 94% for clinical support workers on day shifts and 95.5% and 95% respectively on nights.

During June 2016 the trust achieved staffing levels of 94.7% for registered nurses and 91.3% for clinical support workers on day shifts and 96.9% and 96.3% respectively on nights.

Where 100% fill rate was not achieved patient safety on in-patient wards was maintained by nurses working additional unplanned hours, cross covering across wards, the multi-disciplinary team and ward manager supporting nursing staff in the delivery of planned care and patient care being prioritised over non-direct care activities. Appendix 1 and 2 details how wards, who did not achieve overall staffing of 95%, maintained patient safety.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors are recommended to note the report.

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney, Director of Nursing, Therapies and Patient Partnership
Contributing authors:	Anne Casey, Head of Performance and Information

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
Click here to enter text.	Click here to enter text.	Click here to enter text.

Appendices provided for reference and to give supporting/ contextual information:
Provide only necessary detail, do not embed appendices, provide as separate reports

Appendix no.	Appendix title
1	Ward Daily Staffing May and June 2016

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	
East	Adelphi	1343	1287	1371.5	1271	713	702	1403.5	1332.5	95.8%	92.7%	98.5%	94.9%	Nursing staff working additional unplanned hours.
	Alderley Unit	874.5	858.5	1328	1316	701.5	639	736	764	98.2%	99.1%	91.1%	103.8%	Altering skill mix. Staff cross covered other wards.
	Bollin	1369	1349	1335	1259.5	865.5	846.5	1235	1154.5	98.5%	94.3%	97.8%	93.5%	Nursing staff working additional unplanned hours. Staff cross covered other wards.
	CARS	937.5	890.5	1177	1090.5	713	685	713	573.5	95.0%	92.7%	96.1%	80.4%	Nursing staff working additional unplanned hours. Staff cross covered other wards.
	Croft	1365.25	1375.05	1577.75	1248	769.5	649	1737	1466.5	100.7%	79.1%	84.3%	84.4%	Altering skill mix. Staff cross covered other wards.
	Greenways A&T	1298	1275	2247.5	2029	713	552	1115.5	1179.5	98.2%	90.3%	77.4%	105.7%	Ward Manager working in the clinical team. Altering skill mix. Staff cross covered other wards.
	LimeWalk Rehab	1151	1098.5	1044.5	975.5	726	659.5	667	597	95.4%	93.4%	90.8%	89.5%	Staff cross covered other wards.
	Saddlebridge	813	778.5	1601.5	1608	742	730.5	975.5	945.5	95.8%	100.4%	98.5%	96.9%	Ward Manager working in the clinical team.
Wirral	Brackendale	1087	1049.5	856.5	857.5	712.5	713.5	702	691	96.6%	100.1%	100.1%	98.4%	*
	Lakefield	998.5	964	1091	996	718	703.5	713	724.5	96.5%	91.3%	98.0%	101.6%	Nursing staff working additional unplanned hours
	Meadowbank	892	947.5	1893.5	1870.5	675.5	675.5	1382	1301	106.2%	98.8%	100.0%	94.1%	Nursing staff working additional unplanned hours. Ward Manager working in the clinical team.
	Oaktrees	1267	1185	1549.5	1354	713	702	386.5	375.5	93.5%	87.4%	98.5%	97.2%	Altering skill mix. Staff cross covered other wards.
	Brooklands	1038.5	903	1490.5	1517.5	722	670	1097.5	1161.5	87.0%	101.8%	92.8%	105.8%	Altering skill mix. Staff cross covered other wards. Ward Manager working in the clinical team. Nursing
West	Beech	1472.5	1398	1038.5	999.5	721.5	720.5	874	872	94.9%	96.2%	99.9%	99.8%	Altering skill mix. Staff cross covered other wards.
	Cherry	1265.5	1133.5	1046.5	886	736	701.5	954.5	654	89.6%	84.7%	95.3%	68.5%	Cancelling nondirect care activity. Staff cross covered other wards. Nursing staff working additional unplanned hours
	Eastway A&T	1227	1117	883.5	873.5	593	592.5	720.5	719.5	91.0%	98.9%	99.9%	99.9%	Ward Manager working in the clinical team. Altering skill mix. Staff cross covered other wards.
	Juniper	1633.5	1586	1034	965.1	713	713	828	828	97.1%	93.3%	100.0%	100.0%	Altering skill mix. Staff cross covered other wards.
	Maple Ward	1104.5	1046.5	1472	1427	540.5	529	943	920	94.7%	96.9%	97.9%	97.6%	Altering skill mix. Staff cross covered other wards.
	Pine Lodge (YPC)	985.5	869.5	1184.5	1104	529	494.5	1081	1046.5	88.2%	93.2%	93.5%	96.8%	Altering skill mix. Staff cross covered other wards. Ward Manager working in the clinical team. Nursing
	Rosewood	1010	845	1376.5	1293.5	379.5	379.5	805	801	83.7%	94.0%	100.0%	99.5%	Altering skill mix. Staff cross covered other wards.
	Willow PICU	1046.5	982	1050	1061.5	724.5	713	747.5	724.5	93.8%	101.1%	98.4%	96.9%	Altering skill mix. Staff cross covered other wards.
	Trustwide	**24179.25**	**22938.55**	**27649.25**	**26003.1**	**14421.5**	**13771.5**	**19817**	**18832**	94.9%	94.0%	95.5%	95.0%	

	Ward	Day				Night				Fill Rate				Safe Staffing was maintained by:
		Registered		Care Staff		Registered		Care Staff		Day		Night		
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	
East	Adelphi	1311	1239	1225	1202	767	767	1163	1057	94.5%	98.1%	100.0%	90.9%	Nursing staff working additional unplanned hours.
	Alderley Unit	879	818.5	1378.5	1387	679	686	717	694	93.1%	100.6%	101.0%	96.8%	Altering skill mix. Staff cross covered other wards.
	Bollin	1119	1101	1397	1457	744	771	1261	1264	98.4%	104.3%	103.6%	100.2%	*
	CARS	876	844	1168	1127	702	686	690	551	96.3%	96.5%	97.7%	79.9%	Nursing staff working additional unplanned hours. Staff cross covered other wards.
	Croft	1057	977.35	1736.5	1366.5	750.5	697	1480.5	1216	92.5%	78.7%	92.9%	82.1%	Altering skill mix. Staff cross covered other wards.
	Greenways A&T	1267.5	1205.5	2291	1885	690	560	1380	1441.5	95.1%	82.3%	81.2%	104.5%	Ward Manager working in the clinical team. Altering skill mix. Staff cross covered other wards.
	LimeWalk Rehab	958.3	913.3	1168	1083	685	652	690	651	95.3%	92.7%	95.2%	94.3%	Staff cross covered other wards.
	Saddlebridge	937	925	1372	1378	678	678	857	857	98.7%	100.4%	100.0%	100.0%	*
Wirral	Brackendale	1222.4	1117	684	684	714	714	679	679	91.4%	100.0%	100.0%	100.0%	*
	Lakefield	1174.5	1184.5	1105	997	690	679	679	657	100.9%	90.2%	98.4%	96.8%	Nursing staff working additional unplanned hours
	Meadowbank	915.5	840.5	1423.5	1331.5	635	608	975.5	844	91.8%	93.5%	95.7%	86.5%	Nursing staff working additional unplanned hours. Ward Manager working in the clinical team.
	Oaktrees	1261.5	1237.5	2174	1290	690	702	427	393	98.1%	59.3%	101.7%	92.0%	Altering skill mix. Staff cross covered other wards.
	Brooklands	1188.5	967.5	1375	1351	675	608	1029	1102	81.4%	98.3%	90.1%	107.1%	Altering skill mix. Staff cross covered other wards. Ward Manager working in the clinical team. Nursing staff working additional unplanned hours.
West	Beech	1278	1187	1144.5	1180.5	632.5	632.5	713	695	92.9%	103.1%	100.0%	97.5%	*
	Cherry	1187.7	1173.2	950.5	933	655.5	632.5	927.5	893	98.8%	98.2%	96.5%	96.3%	*
	Eastway A&T	1294	1186	906	837	582.5	508	1062	1062	91.7%	92.4%	87.2%	100.0%	Ward Manager working in the clinical team. Altering skill mix. Staff cross covered other wards.
	Juniper	1599.5	1533	931.5	918	713	689	667	666	95.8%	98.6%	96.6%	99.9%	*
	Maple Ward	1085	1029.5	1242	1115.5	425.5	425.5	977.5	989	94.9%	89.8%	100.0%	101.2%	Altering skill mix. Staff cross covered other wards.
	Pine Lodge (YPC)	963	968	1173	1150	529	529	908.5	897	100.5%	98.0%	100.0%	98.7%	*
	Rosewood	995.5	888.5	1372	1223.5	372	372	713	690	89.3%	89.2%	100.0%	96.8%	Altering skill mix. Staff cross covered other wards.
	Willow PICU	1007.5	982.5	966	920.5	667	659.5	724.5	724.5	97.5%	95.3%	98.9%	100.0%	*
	Trustwide	**23577.4**	**22318.35**	**27183**	**24817**	**13676.5**	**13256**	**18721**	**18023**	94.7%	91.3%	96.9%	96.3%	

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Update to CWP's response to Southern Health NHS Foundation Trust independent report recommendations
Agenda ref. no:	16/17/38
Report to (meeting):	Board of Directors
Action required:	Comments and/ or recommendations sought
Date of meeting:	27/07/2016
Presented by:	Avril Devaney - Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	No
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
Risk of harm to patients, carers and staff as well as reputational and litigation risks due to: a/ unable to show consistent investigation of incidents; b/ unable to show learning from actions of incidents, claims etc. is cascaded; c/ unable to be assured investigations are carried out in a timely manner; d/ inability to communicate in a timely manner with partners	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

To provide an update on how CWP continues to implement its continuous improvement plan developed in response to the learning identified from the independent report into unexpected deaths of people accessing services at Southern Health NHS Foundation Trust over a four year period since April 2011. CWP is committed to learning from external recommendations as an opportunity to strengthen its own systems and processes further. Serious incident management continues to be a strategic risk for the Trust and therefore this report is an opportunity to review its current controls and assurances, as well as strengthen collaborative working with commissioners and other partner organisations (including as informed by mortality reviews) within the wider care system, so that the system as a whole aspires to securing the most efficient, effective and appropriate investigation of unexpected deaths, irrespective of the service/s a person has accessed within the community.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

An independent report, commissioned by NHS England, found that between April 2011 and March 2015, Southern Health NHS Foundation Trust failed to investigate the unexpected deaths of more than 1,000 people. The key findings from the report are:

- The trust could not demonstrate a comprehensive systematic approach to learning from deaths.
- Despite the trust having comprehensive data on deaths, it failed to use it effectively.
- Too few deaths among those with learning disability and over-65s with mental health problems were investigated, and some cases should have been investigated further.
- In nearly two-thirds of investigations, there was no family involvement.

In response to the independent report, the Care Quality Commission (CQC) is currently undertaking a national review of how NHS trusts investigate and learn from deaths.

Assessment – *analysis and considerations of options and risks*

Through a focus on continuous improvement, CWP continues to strengthen its delivery plans for managing the investigation of serious incidents. Key updates detailed in Appendix 1 are:

- A current pilot of an enhanced approach to the review of investigation reports prior to sign off. This has strengthened executive oversight of the quality of investigations and facilitated more appropriate measures being put in place to learn from issues identified, locally and Trustwide.
- Employment of bank Investigating Managers to support the quality and consistency of investigations and learning, as well as to introduce capacity.
- Implementation plans developed to meet the requirements for the Learning Disability mortality review programme (which needs to be fully in place by September 2016).
- Identification of a review of all deaths known to CWP, using a stratified sample.

Work with the quality leads from the CCGs will be revisited pending further guidance from NHS England. CWP also remains committed to working with all of its other partner organisations to ensure a true system-wide response as recommended in the independent report. This includes full engagement with system-wide mortality reviews which may emerge, and exploration of joint working with other provider trusts regarding reciprocal arrangements to support objectivity of investigations. The Medical Directos across the North West are planning to discuss this in September 2016.

The Trust is currently responding to the survey provided by the CQC, as aforementioned. CWP was consulted by NHS Providers regarding the review methodology. 12 trusts have been selected for more in-depth site visits (CWP is not one of these). By December 2016, the CQC plans to:

- Publish a report setting out its findings and recommendations.
- Provide clear guidance for NHS trusts that describes the expected good practice in identifying, reporting and investigating deaths and embedding learning to improve care.
- Use the findings in the report to improve the way they monitor and regulate services.

CWP will update its continuous improvement plan and strategic risk treatment plan in response.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors is asked to **note** the updated continuous improvement plan in response to the recommendations in the Southern Health NHS Foundation Trust independent report.

Who/ which group has approved this report for receipt at the above meeting?	David Wood, Associate Director of Safe Services
Contributing authors:	Audrey Jones; David Wood

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	20 July 2016

Appendices provided for reference and to give supporting/ contextual information:

Appendix no.	Appendix title
1	Continuous improvement plan in response to Southern Health independent report recommendations updated July 2016

16/17/38 Appendix 1

Action plan title	Continuous improvement plan in response to Southern Health independent report recommendations
Action plan authors	Audrey Jones, Head of Clinical Governance David Wood, Associate Director of Safe Services
Executive lead	Avril Devaney, Director of Nursing, Therapies & Patient Partnership
Date of development	22 March 2016 (iteration 1)
Date/s of next scheduled reviews	27 July 2016 (iteration 2) 30 November 2016 (iteration 3)

***Theme:* Board Leadership and Oversight**				
Action identified (for Southern Health)		**Current CWP assurance**	**Further improvement actions for CWP**	**Update July 2016**
1a	The Board needs to ensure the processes of reporting and investigating unexpected deaths are consistent and robust throughout the organisation and to improve the quality of investigations and the involvement of families in those investigations. The Trust needs to prioritise the review of deaths as part of a wider mortality review process making better use of data available.	▪ The Board receives oversight of an exception report at each meeting, reporting on all serious incidents. ▪ The Board receives information about deaths via the Learning from Experience report three times per year. ▪ The Executive Team receive notifications of all serious incidents that are reported on the StEIS system on the day that they are reported. ▪ Duty of Candour compliance is recorded and monitored via the Datix system, furthermore, the engagement and involvement with family is checked by the weekly Meeting of Harm. Further, involvement is captured	i. To set up a process for all serious incident reports to be signed off by a review team meeting. This meeting will involve an Executive Director, Non Executive Director, a member from the Safe Services Department, the Investigation Manager and one other Director/ Clinical Director. Pilots to take place in March 2016, the full meeting to commence April 2016. ii. Head of Clinical Governance to undertake an audit in relation to compliance with Duty of Candour by 15 April 2016.	i. Review meeting commenced March 2016 as a pilot. Terms of reference reviewed and updated post pilot. Positive feedback has been offered by the Non Executive Directors and by the Investigating Managers who have attended. The meetings will continue. A further review should be undertaken November 2016. ii. An initial review was undertaken to establish the focus of the audit and to help develop the terms of reference. The initial compliance findings were

		within the final investigation report. ▪ Incident investigator training includes coverage on the duty of candour and involving families in investigations. ▪ The Trust is appointing a Clinical Champion to support the Trust in improving the quality of investigations, action planning and embedding the learning from incidents.	iii. A toolkit to support a consistent approach to all "serious" investigations (including HR and safeguarding) is currently being developed by the Heads of Clinical Governance, Safeguarding and Human Resources, for completion end April 2016.	reported in the Learning from Experience December 2015 – March 2016. A detailed audit has commenced and will be presented to the Quality Committee 7 September 2016. iii. Heads of Clinical Governance, Safeguarding and Human Resources met initially to develop the toolkit, subsequent meetings were indicated to ensure coverage of each investigatory area. A draft will be available for feedback in September 2016.
1b	The Board needs to understand and make full use of the data available and the underlying information required for assurance that unexpected deaths are being properly identified and investigated.	As 1a.	i. Discussion and agreement, on an ongoing basis and upon receipt of the routine Learning from Experience report, regarding what information the Board wishes to/ should receive.	As 1a.
2a	2015/16 Annual Report should provide a more transparent breakdown of deaths including an analysis of the themes that occur for people with Mental Health and Learning Disability challenges.	The Trust's Annual Report and Quality Account contains high level data which currently meets the national reporting requirements and guidance.	i. The Annual Report/ Quality Account 2015/16 will be developed to include a detailed breakdown of deaths and analysis of the mortality thematic reviews that have been undertaken.	The mandatory sections of these reports contained information on learning from serious incidents and also inquests. The ongoing Learning from Experience report will continue to include analysis of themes.
2b	Provide data on all deaths of people using a Mental Health or Learning Disability service including service users of the social care service.	▪ All Learning Disability deaths are reported within Datix, a 72 hour safety review on all deaths is submitted to the weekly Meeting of Harm. This meeting identifies the requirement for any further	No further actions currently.	*Learning Disability services* The Trust is undertaking the necessary work to ensure it is in a position to implement the requirements for the Learning Disability mortality review

		investigation. ▪ As 1a.		programme. This needs to be fully in place by September 2016. *All other Mental Health services* Terms of reference are currently being developed to undertake a review of all deaths known to CWP. Cases will be identified by using a stratified sample of these deaths. Terms of reference will be agreed by the end of July, this will include the timeframes for this work. This work will be informed by the outputs of current Trust management and reporting systems and other NHS wide reviews, underpinned by the current review of how NHS trusts investigate and learn from deaths by the CQC. Further updates will be provided in the trimester 2 2016/17 Learning from Experience report.
2c	Outline how many unexpected deaths there have been and in which areas.	The Board receives the number and detail of unexpected deaths which are to be investigated in line with the Trust's serious incidents policy.	As 1bi.	As 1bi.
2d	Outline how many IMAs (equivalent to CWP 72 hour safety review) have been written as a result and how many have progressed to CIR (Critical	Unexpected deaths are discussed at the weekly Meeting of Harm. A decision is made as to the level of investigation that is required after reviewing the 72 hour safety review.	i. A report broken down by specialty will be produced to provide the Board with a summary of unexpected deaths occurring, the numbers requiring	This is an appendix to the current exception report.

	Incident Review) and then onto being a Serious Incident under the 2015 Serious Incident Framework.	The decisions of the meeting are captured on a spreadsheet, recorded on Datix and where appropriate StEIS is updated.	further investigations, and those not requiring further investigations. This will accompany the exception report received by Board (assurance 1a).	
2e	Include a summary of how many deaths are 'pending' for the purposes of investigation with a reason why. This would make the decision-making more transparent as regards to delays in reporting to StEIS.	This is currently discussed and recorded at the weekly Meeting of Harm. This information is currently available within the Datix system.	i. The current report produced following the weekly Meeting of Harm is being developed on an ongoing basis to demonstrate transparency of decision making processes.	A record of the decisions is completed usually 24 hours after each meeting to record this in support of transparency of decision-making.
2f	Provide information to enable trends to be identified and for Board members to become familiar with the information.	Improved reporting of serious incidents and deaths has been incorporated into the exception report provided to the Board.	i. Ongoing work to enhance information provided in the Learning from Experience Report in relation to incidents, unexpected deaths, trends and learning themes.	No further updates.
2g	Provide information which includes the categorisation of all deaths reported to Datix.	As 1a.	As 1a.	No further updates.
2h	Provide data at least twice a year on all deaths. Themes should be reported on which covers at least the previous 6 quarters (or a sufficient number to provide a reasonable sample from which to identify themes). This is particularly important for the Learning Disability arena where numbers of deaths in each quarter will be low and in areas that may not be considered to meet Serious Incident reporting guidance e.g. non-suicide Mental	The Learning from Experience report contains the previous 3 trimesters for deaths reported onto STEIS, including Learning Disability Services. The recommendations and findings from serious incidents are themed.	No further actions currently.	No further updates.

	Health deaths.			
2i	There is clear national and Trust policy guidance on reporting and investigating deaths. Trust policy includes a full set of templates and processes – the Board should ensure these policies are being followed and templates being used.	Policy and procedures are in place and specifically relate to reporting and investigating incidents and deaths. The Trust policy is in line with the NHS England framework. An investigation toolkit is currently being developed in partnership between the Safe Services, Human Resources and Safeguarding Departments.	i. As 1aiii. ii. Compliance against Trust policy to be provided to the Quality Committee on an annual basis, commencing September 2016.	i. As 1aiii. ii. Further updates will be provided in the trimester 2 2016/17 Learning from Experience report.
Theme: **Monitoring mortality and unexpected deaths/ attrition**				
3	Unexpected deaths should be defined more clearly. We suggest the Trust uses, as a starting point, the classification outlined in this report to identify the potential need for review or investigation in each case. In particular, the definition of an 'unexpected death' needs to be refined to be more applicable to the circumstances of people with a Learning Disability regardless of setting.	The Trust's weekly Meeting of Harm monitors all unexpected deaths. A 72 hour safety review is presented by the locality and the meeting makes a decision as to the level of investigation that is required. If a decision is made not to undertake any further investigation – this will be discussed and agreed with the relevant CCG. All decisions are recorded within a spreadsheet and recorded after every meeting onto the Datix system.	i. The Trust's incident reporting and management policy will be updated immediately to include a definition of an unexpected death to incorporate the recommendations.	i. The Trust's incident reporting and management policy further requires updating to reflect other definitions requiring clarity, to include emerging mortality reviews for Learning Disability deaths, and further to consider including a flow chart of potential triggers which could suggest further investigation is required. The policy will be updated as and when there is clarity, including in response to the recommendations of the CQC national review.
4	The Trust should develop a Mental Health and Learning Disability Mortality Review Group which includes reviewing unexpected deaths which do not constitute a serious incident. Clear terms of reference should be	The Trust currently works with acute trusts with some joint investigations as a result of serious incidents.	i. This will be considered further as part of the iterative development of the joint improvement plan with all the Trust's quality leads from the CCGs and will be revisited/ completed pending further	No further updates in addition to specific CWP work progressed to-date (awaiting further national guidance and pending local and regional work with safeguarding groups, local authority, CCGs

	developed. This group should serve a number of purposes: a. to provide oversight of all deaths occurring amongst the Trust's Mental Health and Learning Disability service users b. develop a mortality dashboard which is provided to stakeholders and reported in the annual report, that provides a full picture of all deaths, themes, CIRs and serious incidents c. monitor causes of deaths amongst its service users by using the 2013/14 MHMDS data release to see if the ICD 10 chapters show any trend d. provide an evidence base to share with Local Authority commissioners and other providers highlighting themes that are arising relating to social care and other agencies issues e. to ensure that liaison with acute provider colleagues can take place at a clinical and managerial level where the Trust has concerns raised with it about care in acute settings should include a GP as part of its membership g. the formation and progress of this new group should be monitored at Board level h. the group must aim to improve the transparency of reporting		guidance from NHS England.	etc).

	levels of unexpected deaths in these service user groups.			
***Theme:* Thematic Reviews**				
5	A template for a thematic review should be produced. All thematic reviews should be undertaken in an agreed format which meets best practice standards and includes follow up, evaluation and demonstration of lessons learned and practice change.	The Trust currently uses a format for thematic reviews.	No further actions currently.	As 1aiii.
6	There should be further work undertaken to establish whether deaths of people over the age of 65 are being appropriately reported and investigated – in particular amongst inpatients.	Reporting of reportable deaths takes place via Datix. As stated previously, these reported deaths are then discussed at weekly Meeting of Harm.	No further actions currently.	As 2b.
7	The Trust should provide staff with regular training and guidance to help them manage physical health conditions of long-term mental health service users. Diabetes management stands out as an area for greater awareness from a number of cases we reviewed.	Physical healthcare training is delivered across the Trust, the delivery and effectiveness is monitored by the physical healthcare clinical network.	i. Physical healthcare clinical network is currently updating its assurance framework to incorporate learning from external organisations and will therefore incorporate this area also.	No further updates.
8	The Trust should undertake thematic reviews of the issues raised in this report, including: a. Medical input and senior medical oversight b. The role of the care co-ordinator c. The need for pharmacy colleagues to be more explicitly involved in cases involving drug	These were specific issues to Southern Health. CWP identifies themes from serious incident reports and thematic reviews are undertaken when required.	No further actions currently.	No further updates.

	toxicity and polypharmacy.			
9	A regular review of all sudden deaths of OPMH inpatients should be carried out. This should include a review of whether care treatment decisions are taken quickly enough, whether co- operation and liaison with acute medical staff is adequate and whether staff feel confident in managing and identifying sudden physical deterioration including CPR.	All unexpected deaths within CWP inpatient settings are reported on Datix, with a 72 hour safety/ mortality review undertaken and shared with the weekly Meeting of Harm.	No further actions currently.	No further updates.
***Theme:* Reporting and identifying deaths**				
10	The Trust should review the way that deaths are categorised under the incident reporting policy so that: a. All relevant deaths are re-graded accurately before and after investigations have taken place. b. All relevant deaths are reported on regardless of impact grading to ensure that deaths have greater prominence in the Trust's reporting systems. c. Accurate information is provided for future Trust Mortality Reviews. d. That immediate work with the NRLS team is undertaken to ensure the changes to the local risk management system map as expected to NRLS and on to CQC.	The Trust policy includes guidance on categorisation of incidents. Deaths are graded by the reporter and quality assured by the manager, overseen by the Safe Services Department.	i. Safe Services Department is currently working through an action plan to improve the quality of reporting and data completion in relation to incident reporting, in partnership with the NRLS. This is due to be completed during the course of quarter 1 of 2016/17.	The initial actions have been completed. The incidents team revisit the incident once the outcome of the inquest is known to ensure accurate mortality data. Further, the incidents team are now working to a programme of data quality improvement which is ongoing throughout 2016/17 – this includes migrating complaints, claims, legal and inquests onto the incident reporting and management policy. This allows a whole system governance approach which will further support a case management approach and facilitate better analysis of trends.
11	The Serious Incident investigation process needs a major overhaul in	▪ Bank investigators are currently being recruited.	No further actions currently (further actions pending	Bank investigators have been recruited and have

	the Trust. a. Separation of people responsible for quality assurance and those undertaking investigations. This would enable training in review processes and quality assurance to be targeted at senior staff and in investigation techniques at a dedicated group of investigators. b. Quality assurance processes including independent review and sign off. c. Achieving high professional standards in written presentation. d. Timeliness of investigations.	▪ Improved training and support for investigating managers has been implemented. ▪ Corporate and Executive oversight by newly formed investigation review meetings taking place every two weeks. ▪ Independent review is achieved through CCG closure panels' scrutiny. The employment of a Clinical Champion for investigations.	feedback from the pilot of the investigation review meetings).	commenced investigations. Further training has been organised and delivered, with workshops targeting specific aspects of undertaking investigations. Review meetings have been set up since April (as 1ai). CCGs continue to oversee (via secondary governance) the investigations of CWP through their own closure panels. Clinical services and the incidents team engage with feedback offered and act on feedback which is appropriate. The Clinical Champion role has been advertised twice, further thinking is required to understand the function of this proposed post before considering a further attempt at recruitment.
12	Reporting to StEIS should be undertaken within the 2 working days of notification as required by the national guidance.	The Trust is compliant of reporting to StEIS within 2 days of knowing that an incident is a serious incident.	No further action currently.	No further updates.
13	There should be more explicit action to commence investigations promptly even when a coroner conclusion is not immediately available unless there is a specific reason to delay; any delay should have senior sign off.	The death reporting and incident procedure is specific that delays do not occur in reporting or commencing an investigation unless there is a specific and recorded reason for doing so.	No further action currently.	No further actions.
***Theme:* Involvement of families**				
14	The involvement of families in	The Trust has clear guidance in	i. The audit for Duty of Candour	As 1aii.

	investigations requires improvement. In particular, improvements are needed in: a. developing clear guidelines for staff, including expected timescales and core standards, which recognise the need for iterative engagement when the family is ready b. ensuring that the investigation process is clearly defined and separate from the support and assistance offered by local treatment teams c. the Trust should ensure that investigators talk to families as early as possible in the process to identify any concerns and take these into account in the ensuing investigation d. provide reports to coroners in time for inquests e. explicitly demonstrating why families are not involved identifying next of kin details for all service users as part of a core assessment including where consent to share has not been provided to enable investigators to find relatives more easily f. working with primary care to identify family members g. where the Trust delays the commencement of an investigation due to inquests or other investigations this should be	place, compliance is checked at the weekly Meeting of Harm and is included in the investigation report. An audit is currently underway to establish if there are any gaps in relation to these points. This will be completed, with an action plan, by April 2016 and reported in the Learning from Experience report (see 1aii). The Trust has a system and process for allocating a Family Liaison role which is instigated as soon as the Trust is aware of an unexpected death.	which is due August 2016 and will be undertaken twice a year will incorporate the recommendations for involvement of families. An action plan will be developed to address any gaps.	

	made explicit to families and the reasons explained h. the performance of divisions in involving families and securing feedback.			
		***Theme:* Multi-agency Working**		
15	The Trust Board should seek co-operation with other providers and commissioners to agree a framework for investigations in preparation for future incidents regarding escalation. Divisions should then apply this framework where the incident report suggests another organisation should review or investigate the circumstances of a death.	Collaborative working is being developed and considered within the Terms of Reference within investigations. This includes acute trusts, CCGs and GPs. This would be extended to include other social, health and voluntary organistions when appropriate.	i. See 4i (no other further actions currently).	The incidents team manager and Head of Clinical Governance attend serious incident meetings across all CCGs. Western Cheshire CCG and CWP are piloting the incorporation of GP significant event analysis into investigations if available and if appropriate. Multi-agency working will also be discussed at the September meeting of the North West Medical Directors. Further, the CQC national review is likely to identify further recommendations in response to this theme.
		***Theme:* Deaths in detention and inpatient deaths**		
16	The Trust should retain a contemporaneous list of all inpatient deaths mapped to Mental Health Act status to enable Trust-wide overview of all inpatient deaths and deaths in detention.	All inpatient deaths of individuals subject to detention under the Mental Health Act are reported and also reported to the CQC.	No further action currently.	No further updates.
17	All deaths of service users in detention should be investigated, whether expected or not. These investigations should occur regardless of inquest conclusions.	It is CWP policy to investigate all inpatient deaths of individuals subject to Mental Health Act detention.	i. The Trust's incident reporting and management policy will be updated immediately to incorporate the issues identified in the recommendations.	No further updates.

	This will give assurance that the 24/7 nature of the care required has been of the highest standard. Specific issues addressed in the Terms of Reference for these investigations should include: a. to ensure that physical health care symptoms are not dismissed where challenging behaviour presents; b. that delays in seeking physical health care are not apparent; c. that service users are fully aware of decisions regarding whether to treat or investigate chronic or acute symptoms and that these are made in an informed manner; d. that access to full care and treatment is not restricted in any way; e. that staff are adequately supported to provide physical health care and trained to do so.		ii. The recommendations will now be included in the training for investigating managers, within the investigatory toolkit and furthermore the new review team for investigations will be informed to consider these.	
		***Theme:* Information management**		
18	The Trust should develop an agreed RiO extract and Ulysses reporting protocol to capture all deaths of Adult Mental Health, Older People Mental Health and Learning Disability service users including community and inpatient locations to form the basis of future mortality review. *(For CWP this is CAREnotes and Datix.)*	▪ The Trust has completed a mortality review for NHS England in March 2016. ▪ The Trust will await further guidance from NHS England as to what process should be in place for all Mental Health trusts (guidance is expected to report on the development of case reviews of most deaths for mental health trusts by 2017).	i. The Safe Services Department will provide a quarterly report on all deaths of Adult Mental Health, Older People Mental Health and Learning Disability service users, including community and inpatient locations. This will commence for quarter 1 of 2016/17 and will be shared with locality Learning from Experience groups to then	Safe Services Department has provided a report on all deaths reported on its clinical management and reporting systems. This was presented at a mortality meeting with the Director of Nursing, Therapies and Patient Partnership, Associate Director of Safe Services, Head of Clinical Governance, Head of

			inform the aggregated Learning from Experience report to Quality Committee and Board.	Safeguarding, and Incidents Team Manager. This identified the further action identified in 2b.
19	The spreadsheet arrangement currently in place in TQ21 is insufficient to monitor deaths at corporate level as part of the whole Learning Disability service provision. TQ21 service users should be incorporated into Trust administration systems in a way which ensures their deaths are captured for reporting and investigation purposes.	CWP provides reports to monitor deaths for the weekly Meeting of Harm. All information is recorded onto Datix.	No further action currently.	No further updates.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Director of Infection Prevention & Control Quarter Annual Report 2015/16
Agenda ref. no:	16/17/39
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	27/07/2016
Presented by:	Andrea Hughes, Director of Infection, Prevention and Control

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
36T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
36T	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

Attached at appendix 2 is the Annual Report 2015/16 for Infection Prevention and Control (IPC). Quarterly and annual reporting to the Board of Directors is a mandatory requirement and requires noting.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
The Director of IPC or Nurse Consultant for IPC, delivers a quarterly and annual report to appraise the Board regarding IPC activity and any associated risks.

Assessment – *analysis and considerations of options and risks*
See appendix 1 for full report.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors is asked to **note** the Annual Report for 2015/2016.

Who/ which group has approved this report for receipt at the above meeting?		IPCSC – July 2016
Contributing authors:		Amanda Miskell
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Chief Executive	July 2016

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	2015/16 Annual Director of IPC report

16/17/39_Appendix 1

INFECTION PREVENTION & CONTROL

ANNUAL REPORT 2015-2016

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1. Introduction

The purpose and content of this annual report is to provide an overview of the Infection Prevention and Control (IPC) activities from April 2015 to 31st March 2016, and to highlight service achievements and the progress made against the priorities outlined in the Infection prevention and Control Sub Committees (IPCSC) work programme.

High standards of infection prevention and control are crucial to ensure prevention of infection in all health care facilities within CWP. To support this, the IPC Integrated Service, which compromises of CWP IPCT and CWaC IPCT colleagues, continues to work hard to prevent all avoidable infections and the risk of resistant organisms across our Health & Social Care footprint.

The team use the trust values in all areas of their work on a daily basis.

We encourage communication with our staff by being visible in the localities, having link practitioners, providing newsletters and attending key meetings.

We are committed to providing evidence based care.

We have the courage to challenge ANY behaviour that puts our services user, carers, visitors or staff at risk.

We are dedicated to maintaining the competence required in relation to preventative IPC practice.

We are compassionate in all our contact with patients, carers and colleagues.

We are committed to preventing ANY avoidable infection.

Below is a brief summary of the IPC team activities and how we continue to raise the profile of both CWP and the IPC Integrated Service:

- **No** preventable Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections within our provider services
- **No** preventable Clostridium Difficile Toxin (CDT) infections within our provider services
- **Actively** involved in Public Health England (PHE) presenting on collaborative working and antimicrobial stewardship.
- **Achieved** a zero number of identified cross infection cases in service users or staff (excluding small round structured virus outbreaks)
- **"Super User"** advisor for the National Infection Prevention Society (IPS) Quality Improvement Tools
- **National** conference speaker and national poster presentations for the FOURTH consecutive year
- **National** Education Professional and Development Committee member for the Infection Prevention Society (IPS)

- **Active** members of national Mental Health IPS Special Interest Group
- **Successful** appointment to the North West IPS Education Officers role for a two year term
- **Regional** conference speaker and poster presentations at regional conferences,
- **Regional** IPS conference chair
- **Member** of the North West Sepsis group
- **North** West IPS and PHE meetings hosted at CWP, raising our profile for IPC

2. Summary of the Director of Infection Prevention and Control's (DIPC) reports to the Board of Directors (BoD)

2.1 Frequency/nature of reporting

In addition to delivering the annual report the DIPC delivers a quarterly report produced by the Nurse consultant. During 2015/16, the Board received concise reports in accordance with the business cycle, which highlighted areas of practice and development, including arrangements for IPC.

2.2 Decisions made by the Board of Directors

The approval and any recommendations from the Board are communicated directly to the DIPC following presentation of Quarterly and Annual Reports and are actioned accordingly**.**

3. Care Quality Commission

The Care Quality Commission (CQC) inspection during 2015 did not highlight any IPC gaps. The CQC assess IPC standards against the new Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance (Department of Health, 2015) which contains the ten criterions that healthcare providers are assessed against.

Before publication in July 2015, the nurse consultant had consolidated further assurance for the board in relation to the new standards which included Water safety and antimicrobial stewardship. A summary of assurances was sent to the Chief Executive in May 2015 and approved at the following board in 2014/2015 quarter 4 DIPC report. Those assurances are now embedded within the IPC assurance framework for 2015/2016.

CQC Regulation 12 and 15shown below are also addressed within the assurance framework:

Regulation 12 – Safe care and treatment, "Providers must prevent and control the spread of infection. Where the responsibility for care and treatment is shared, care planning must be timely to maintain people's health, safety and welfare".

Section 2h – "Assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated". When assessing risk, providers should consider the link between infection prevention and control, antimicrobial stewardship, how medicines are managed and cleanliness.

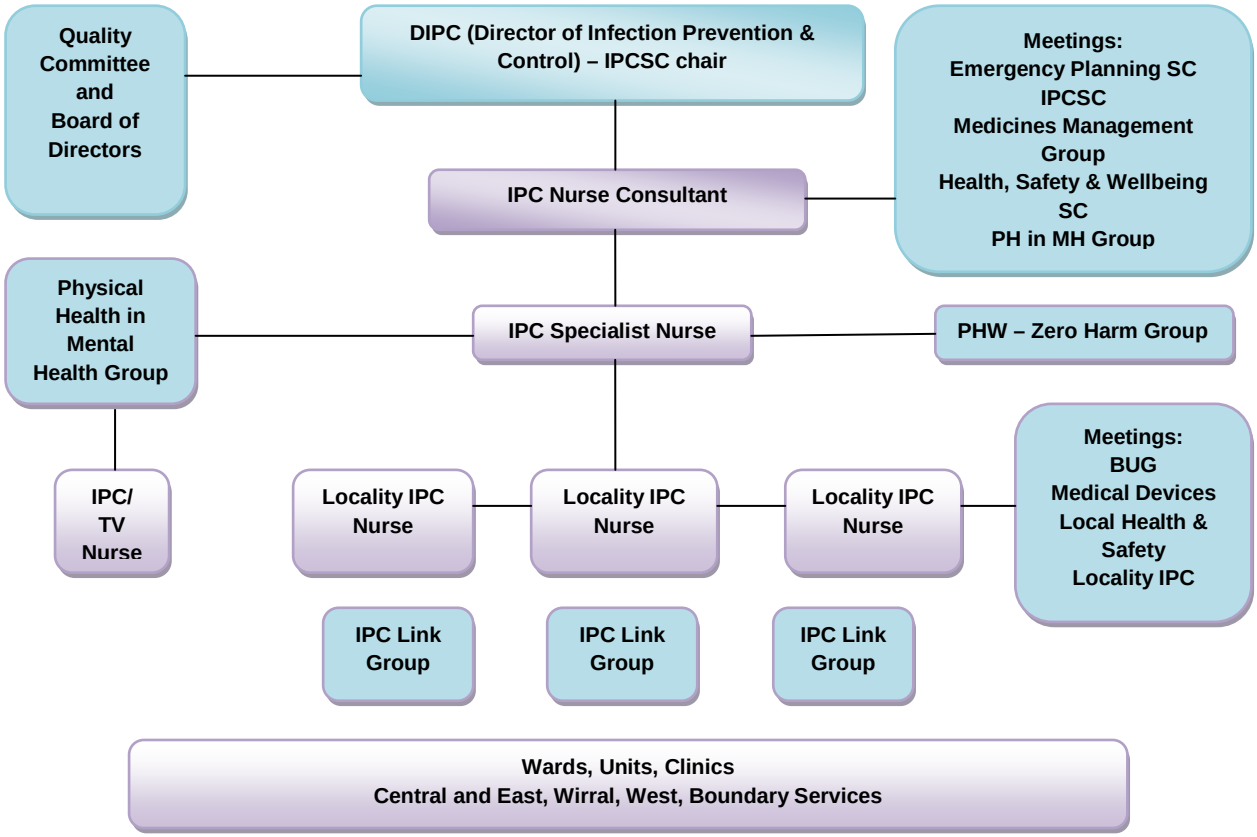
Regulation 15 – Premises and Equipment, "The intention of this regulation is to make sure that the premises where care and treatment are delivered are clean, suitable for the intended purpose, maintained and where required, appropriately located, and that the equipment that is used to deliver care and treatment is clean, suitable for the intended purpose, maintained, stored securely and used properly".

Section 15.2 – "The registrant must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used".

4. Infection Prevention and Control (IPC) governance arrangements

4.1 Arrangements for IPC services

The IPCT have a high profile within Clinical Services and support services across the CWP footprint. We also provide support to the Public Health England (PHE) Team of Cheshire West and Chester, Western Cheshire Clinical Commissioning Group (CCG), Vale Royal CCG and Support Units (CSU). Diagram below shows "Ward to Board" structure and attendance at meetings.



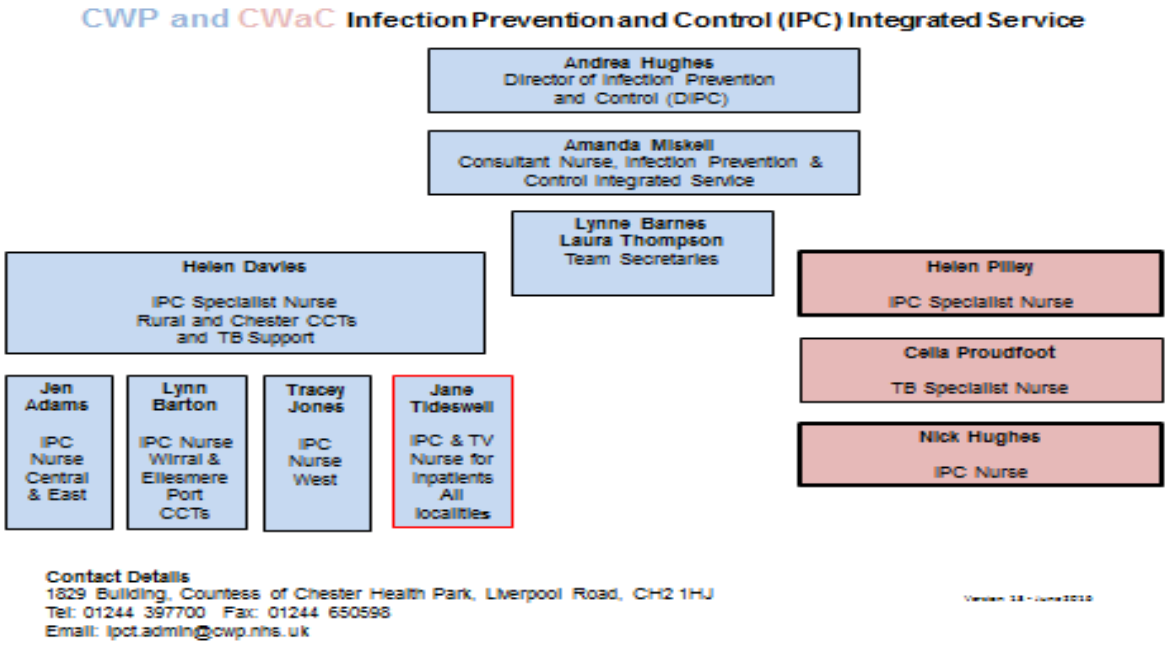
4.2 Infection Prevention and Control subcommittee (IPCSC)

The IPCSC reports directly to the Quality committee, and is chaired by the DIPC or Nurse Consultant. Meetings take place five times per year, and all services and localities are represented. During 2015/2016 a meeting effectiveness review was carried out. The IPCSC evaluated very well by committee members, with some areas scoring 100% positive.

4.3 The IPC Integrated Service

Following a review of service, the structure of the IPC team has responded to provide a more efficient service across the three localities and other CWP teams for mental health, learning disabilities and harm reduction services. The DIPC (Andrea Hughes replaced Maria Nelligan in October 2015) is supported by the IPC team which is led by the Nurse Consultant, supported by a specialist nurse and three locality IPC nurses.

Following a review of the trust wide antimicrobial prescribing and the risks associated with infections a role was developed to support all inpatient areas in zero harm, safety thermometer, immunisation, invasive devices and tissue viability. This role is a "community PH nurse for inpatients" which will commence in June 2016. The role was approved by the board and is funded from the efficiencies of the IPC team review. This is in addition to the CWaC component of the team as below:



4.4 Local IPC groups

Modern Matrons and IPC link practitioners throughout the trust are supported by the IPCT to deliver the IPC agenda locally. IPC link practitioner groups are well established in each locality. These groups meet on a quarterly basis and provide an excellent opportunity to cascade and disseminate key IPC guidance to staff. An education element is also incorporated to promote Continuing Professional Development (CPD).

The IPCT held their 12th annual IPC study day in November 2015 with in excess of 50 members of staff attending from a wide variety of CWP services. As in previous years this event provided an excellent stage for learning and networking with colleagues. The IPCT were able to secure the support of several outside speakers to provide an engaging and thought-provoking event, and look forward to facilitating this event again in December 2016.

4.5 IPC resources

The following resources are available to all CWP patients, staff and carers:

- The team
- IPC policies – which are reviewed in line with the IPCSC work plan.
- An IPC web page – a direct link provided on the CWP intranet home page, updated with new announcements, link minutes, useful codes, links to the CQC, Gov.uk guidelines and all other relevant publications. This page is regularly updated and feedback on areas for development actioned as required. http://nww.cwp.nhs.uk/TeamCentre/IPC/Pages/home.aspx
- An IPC newsletter – highlighting good practice, recommended products, training sessions, and infection prevention control tips and advice.
- Library resources – containing over 30 books, providing a range of information under the sub section of IPC for all staff, plus the Journal of IPC which is published bi-monthly.

4.6 CWP's commitment to Infection Prevention and Control 2016 -2020

This document is in development and will be presented to board in September 2016 as part of the Quarter 1 DIPC report. The commitment has been produced to support the person centred framework and the on-going achievements from previous years to reduce avoidable healthcare-associated

infection. The Board of Directors receives regular progress reports on the initiatives that are in place. The key objectives and plans for monitoring improvement are highlighted within the commitment which is supported by the Infection Prevention and Control Subcommittee (IPCSC) work programme and assurance framework.

This commitment will support effective and meaningful infection prevention and control practice of all employees within CWP. It will also ensure that effective measures for prevention and control of infection are integrated in the trust core business, planning and delivery.

The trust aims to prevent the risk of Healthcare Associated Infection (HCAI), throughout the diversity of settings within the Trust.

4.7 IPC Work Programme

The work of the IPCSC is detailed in a work programme which is approved by the Board and reviewed at each Committee meeting. Areas of concern are highlighted and escalated where required.

4.8 Programme of Policy Review

All IPC policies were reviewed during the 2015/16 period, in line with the policy review programme which forms part of the IPCSC work plan. The focus for 2016/2017 is to amalgamate these into a standard operating procedure manual that is more accessible and succinct.

5. Refurbishments and New Builds

The IPCT provide advice and support during refurbishments and new builds across the trust, including advice for primary care premises to ensure compliance with national guidance and the audit programme. The IPCT have continued to work in partnership with CWP Estates in relation to the plans and works carried out for the new young person's inpatient unit, Ancora House, ensuring compliance with Hospital Building Note 00-09. The IPCT also worked with colleagues from the Estates and Facilities departments to support the refurbishment of Croft Ward on the Millbrook Unit.

6. Standardisation of products

The team have supported procurement in standardising the top 15 IPC related items used in CWP. This includes hand decontamination resources, gloves, aprons, disinfectant and patient wipes, dressing packs and cleaning agents as a minimum.

7. Safe Systems for Insulin Pen Device Sharps and exposure incidents

The team review all incidents to reduce risk and promote good practice in relation to needle stick injuries (NSI) and have provided training and posters to all staff to support safer processes. Exposure incidents are potentially high risk, and preventative training and resources are ongoing. Activity in CWP for this year, including storage of recipient or donor bloods as table below:

CWP Only - Accident/Needle Stick Activity
1/4/15 - 31/3/16

Count of Appt. Date	Directorate				
Reason	CWP - East	CWP - Trust Support Services	CWP - West	CWP - Wirral	Grand Total
Accident and (NSI/Bites	4	5	16	7	32

scratches etc.)					
Bloods - Storage	1	1	8	3	13
Grand Total	4	5	16	7	32
2014-2015 Total					45

This shows a decrease in exposure incidents across the three localities. In year 2014/2015 there was 45 incidents showing a reduction of 29%.

8. Hand Decontamination

IPCT continues to actively promote hand hygiene, via observational activities in the workplace, trust induction, Essential 1 Learning and at all other events and opportunities.

The IPCT have been working closely with colleagues from the Facilities Department, along with "GOJO" representatives to complete site surveys in response to the standardisation work for foaming soap, alcohol hand foam and moisturiser. These will be used to update the hand hygiene products across CWP, for both in-patient and community settings. The aim of this is to streamline the number of products used, and therefore achieve the maximum cost savings afforded as a result of bulk ordering. This will ensure effective hand hygiene is accessible to all CWP staff, patients and visitors.

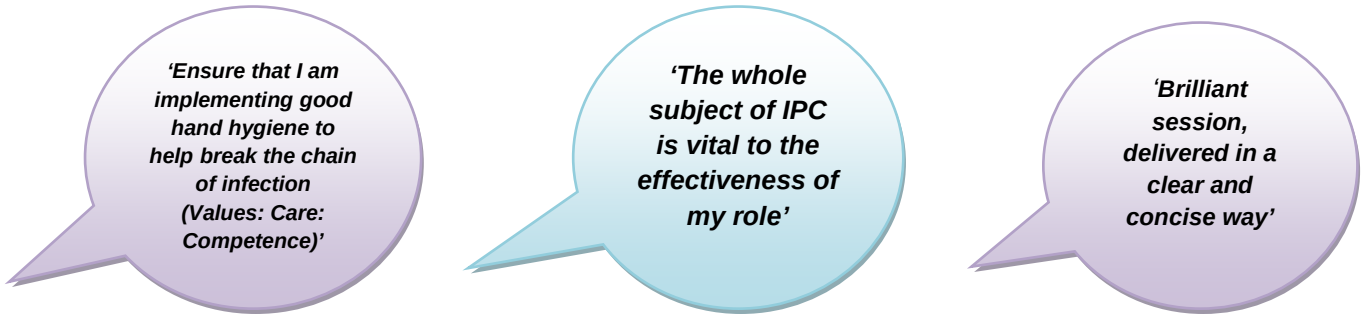
9. Education CWP activity

9.1 Induction and Essential Learning (EE1)

The IPC team have facilitated 15 Induction sessions during 2015-2016, and 78 EE1 sessions plus 13 additional sessions to staff including the support of our e-learning package. This has amounted to 2634 staff having received IPC and hand decontamination training. The team strive to improve compliance by providing extra sessions, targeting low compliance areas and attending key clinical meetings. Specific training has been given to our colleagues in Safeguarding, Estates and Facilities.

The IPCT also support Aseptic Non Touch Technique (ANTT) training, supporting compliance the Safety Metrics and Zero harm.

Throughout the period of this report, the IPC sessions consistently scores "good" or "excellent" in feedback from participants.



Our aim for 2016/2017 is to support a higher compliance rate for CWP by refreshing training resources and delivery methods.

9.2 Continuing Professional Development of the IPC team

In addition to completion of organisational training requirements, the IPC team attends relevant local, national workshops and conferences, including national and regional Infection Prevention Society (IPS) conferences. All IPCT members hold recognised infection prevention and control qualifications, at BSc level and the specialist nurses are all in the process of completing their MSc programmes. The

locality nurse for the East Locality completed the M.I.C.S (Management of an Infection Prevention & Control Service) at the University of Manchester and achieved the highest result in the cohort focusing on Influenza vaccination in Mental Health.

The nurse consultant has gained an MSc in Health Improvement & Wellbeing (PG cert Public Health) and is an Honorary Lecturer at the University of Chester.

The IPCT, supported by the academic unit, has led on a pilot for all the patients with chronic leg ulcers in the Ellesmere Port North &-South Team. The results of which are with West Cheshire CCG/GPs for consideration.

10. IPC standards reviews

10.1 Modern Matron Walkabouts

The IPCT supported a review of the modern matron programme across the trust, resulting in the development of a revised document for use on the monthly walkabouts.

Central & East locality

For Adelphi, Bollin, Crook Lane, Croft and Greenways matron "walkabouts" continue to note improvements around the dress code since the introduction of uniforms. The relationship with locality IPC nurse is effective and staff are confident about contacting her for advice.

West locality

IPC "walkabouts" are completed on each ward on a monthly basis with the facilities managers, and the IPC team support these as required.

Wirral locality

Springview now has the locality IPC Nurse based in the building and this has been of huge benefit to the wards. Ward staff at Springview have all been provided with uniforms and most of the feedback from staff and patients is positive.

10.2 IPC Audits

During the period this report covers the team carried out audits on all inpatient clinical areas**.**

All inpatient areas achieved above the compliance score of 93%.

Results are reported back to the Ward Manager, Modern Matron, Estates and Facilities managers, and the IPCSC where areas of good practice are highlighted and appropriate actions regarding areas of concern is actioned and documented on the risk register if necessary.

During the period this report covers the team carried out audits on all community areas with the appropriate follow up and support. Results are reported back to the IPCSC where areas of good practice are highlighted and appropriate actions regarding areas of concern is actioned and documented.

There are some areas of concern in the community in relation to five premises across the localities in relation to environmental issues, however these are currently on the IPCSC risk register and continually followed up by the IPCT and our colleagues in Estates and Facilities.

11. Integrated Working and Support across Services

The IPCT support investigations and reports to clinical services and one of the team is the professional advisor for nursing in West.

12. Service User Involvement

IPC nurses are involved In the Recovery Colleges by presenting sessions that aim to show how the principles of IPC can be used to maintain aspects of personal health.

13. Health Care Associated Infection (HCAI)

During 2015 – 2016 there were no cases of MRSA Blood Stream infections reported to the IPCT in inpatient service.

There has been one patient in the East Locality diagnosed with C Diff infection. This was during the March 2016 Gastrointestinal Outbreak on Croft Ward. A separate Root Cause Analysis was completed which found that the cause was unavoidable; and was linked to multiple prescriptions for antibiotics, all of which were necessary. All relevant IPC management advice was adopted by staff and the patient affected has since made a good recovery. The case was reported to the Consultant for Public Health and the CCG as required by the Nurse Consultant.

This figure assures the Board that excellent IPC standards exist in inpatient services, and patients are not harmed unnecessarily by HCAI's**.**

14. Outbreaks Inpatient Areas

All IPC incidents and outbreaks are routinely reported to the IPCSC and the Board of Directors, ensuring relevant information and good practice is shared and action plans developed where required. The focus of the IPCT is to prevent outbreaks and if they do occur, to reduce the impact of the outbreak on service users and staff. This is achieved by monitoring environmental cleaning standards, hand hygiene and by ensuring staff can identify a potential outbreak which is addressed during Essential Learning. In order to learn from experience post-outbreak meetings are held for CWP inpatient areas within 5 working days of the end of an outbreak. These meetings may include clinical service managers, modern matrons, ward managers, temporary staffing, occupational health, practice education facilitator and facilities manager.

Central and East locality

There has been one outbreak declared in the Central & East locality. The IPC Team maintained close contact with Croft ward and all outbreak management strategies were put in place and maintained throughout. In total five patients and four staff members were affected. However, on investigation staff and patients were found to have differing symptoms and so it was concluded that they may not be directly linked. The ward was closed by the IPC Service with the support of the DIPC for a total of four days, and opened following a post outbreak clean by Facilities staff.

West locality

No confirmed Outbreaks in West locality.

Wirral locality

There have been two outbreaks declared in the Wirral locality. An outbreak of diarrhoea and vomiting on Meadowbank caused by a patient transferred from another care facility that had Diarrhoea & Vomiting (D/V). In total the ward was closed for 6 days, 6 patients with symptoms and 5 staff off sick with symptoms. No causative agent identified, however the transferring hospital closed with confirmed Norovirus.

Another outbreak of D&V on Lakefield; in total the ward was closed for 8 days, 10 patients with symptoms of vomiting (3 also with diarrhoea) and 7 staff off sick with similar symptoms. No causative agent identified.

Learning from these outbreaks has included an SBAR regarding the procurement of cleaning equipment, mobile sinks and curtains to ensure a timely and efficient deep clean.

15. Surveillance and Safety Metric/Zero harm

The key items for community services are the surveillance and identified risks associated with Pressure Ulcers, Wounds and Urinary Catheters.

All patients with stage two or above wounds in community Physical Health services are screened for MRSA.

The IPCT support and collate all the information for Urinary Catheters in the community where patients are in receipt of community nursing. The nursing teams are supported to use the 10 week catheter pathway, and Aseptic Non Touch Technique (ANTT). Training in ANTT is now provided via e learning.

Inpatient MH services have shown an increase in the number of patients requiring support for tissue viability, which is inclusive of self-harm wounds, cuts and post-operative surgical sites. The IPC nurses for the three localities have had numerous interactions with staff and service users throughout the year. Each episode involves contact, advice to staff and patients were appropriate and documentation on CareNotes. There has been significant increase in IPC contact in comparison to previous years, accessibility and extended hours appear to have stimulated this.

The categories in the table below show approximate contacts and rationales:

	Central & East	West	Wirral	PH West
MRSA advice/screening and treatments	90	27	116	257 (10 week catheter pathway) +17 others
Invasive Devices	14	11	28	269
Skin Integrity	62	43	49	12
Antimicrobial Prescribing	122	131	128	19

In addition to the above the team responded to 151 other contacts with the office asking for advice on IPC issues and concerns over the year 2015/2016.

15.1 Catheter Associated Urinary Tract Infection (CAUTI)

The IPCT have developed and supported the Trust response to the implementation of NICE guidance EPIC 3 (2014) and CQC requirements with regards to Catheter Associated Urinary Tract Infections. This has included the continuing monitoring of all catheterised patients in the community setting with CWP input, on average 250 patients, supporting the introduction of a safety metric, product masking, training, staff meetings, communications, and updating the 10 week catheter pathway.

15.2 Skin-Tunnelled Central Catheter (Hickman) and Peripherally Inserted Central Line (PICCs)

The IPC service have been working collaboratively with other healthcare providers across the Western Cheshire footprint during 2015/2016 on the development of guidance and competencies to support these devices, based on national guidance including NICE and EPIC 3. Patient information leaflets and a PICC passport are nearing completion, allowing continuity and consistency for both patients and staff when more than one care provider is involved in a patients care.

16. Sepsis

Evidence suggests that some cases of sepsis are preventable, particularly in groups of people who are at the greatest risk. Though anyone can be affected, those at the extremities of life – the very young and the very old – are particularly at risk, along with people who are immunosuppressed and pregnant women. For these groups measures to prevent infection and to recognise and treat infection promptly can prevent sepsis from developing.

CWP have a Physical Health and Deteriorating Patient education programme in place. In addition to this there is an Infection Prevention and Control service inclusive of a nurse supporting complex PH needs. CWP has also had a robust Early Warning Score (EWS) system in place across all inpatients areas since April 2012. More recently this has been reviewed and evidence based National and Paediatric EWS, along with Maternity EWS has replaced the Modified EWS in CWP.

In the community setting staff must adhere to CWP policy if a patient is assessed visually as deteriorating from a PH aspect and call the patients GP or 999.

This assessment alone gives inpatients a "parity of esteem" in terms of assessment for sepsis, and a process to refer and transfer responsibly to acute physical health services.

CWP have introduced the following to support the identification and management of sepsis:

- Sepsis is included in all PH in MH training and IPC EE1
- Consideration of a communication bulletin in relation to the key points for considering sepsis
- Review the NICE guidance once published
- Review ALL transfers to acute PH services from CWP with Sepsis and for returning patients
- All clinical nursing and medical staff to complete e learning package, once available.

17. Influenza Immunisation Activity

Four members of the IPCT completed their update of the Immunisation training, in order to be able to support the annual staff influenza vaccination campaign during 2015/16. The team worked in partnership with the Trust's Occupational Health to deliver the vaccine across all localities**.** Despite the national 75% uptake target, CWP agreed a more pragmatic target based on previous uptake with staff, and instead aimed to vaccinate at least 52% of staff which would represent a 10% improvement on the previous year. Sufficient vaccine stock was purchased to achieve the internal target and in the event demand for the vaccine exceeded supply, the delivery model supported the purchase of 'flu vouchers' for distribution to the remaining staff requesting vaccination. These vouchers could then be redeemed at a number of third party pharmacies.

CWP reached a total of 51.5% of face to face staff vaccinated which put us in the bracket of one of the top 5 most improved Trusts.

For 2016, there are national CQUIN targets for Health & Wellbeing of Staff in the NHS. The flu immunisation target for all Trusts is 75% of face to face staff vaccinated by the 31 December 2016.

18. Antimicrobial (AM) Resistance (R) Strategy and CWP work

AMR has risen alarmingly over the last 40 years and the inappropriate use of antimicrobials is a key contributor. The consequences of AMR include increased treatment failure for common infections and

decreased treatment options where antibiotics are vital. Antimicrobial stewardship is crucial in combating AMR and is an important element of the UK Five Year Antimicrobial Resistance Strategy.

Antimicrobial stewardship represents an organisational and system-wide approach to promoting and monitoring the prudent use of antimicrobials by:

• optimising therapy for individual patients;
• preventing overuse and misuse; and
• minimising the development of resistance at patient and community levels.

A patient safety alert from National Patient Safety Agency has been responded to in October 2015 in collaboration with our pharmacy colleagues. This alert was jointly issued by Health Education England, NHS England and Public Health England (PHE) to highlight the challenge of AMR and to signpost the toolkits developed by PHE to support the NHS in improving antimicrobial stewardship in both primary and secondary care.

TARGET (Treat Antibiotics Responsibly, Guidance, Education, Tools) was designed to be used by the whole primary care team within the GP practice or out-of-hours setting, as well as being relevant to mental health care settings.

From 1st April 2015 and following the publication of the new Department of Health, “Code of Practice” (July 2015), the CWP IPC team have been proactive in raising awareness in judicious prescribing of all antimicrobials across inpatient settings. The Code of Practice states that as a registered provider with the Care Quality Commission, CWP has several specific responsibilities including;

- Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. Including targeted training to ensure appropriate AMR stewardship, access to microbiology, advice on choice of therapy

- Systems should be in place to manage and monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised and patients with severe infections such as sepsis are treated promptly with the correct antibiotic

- The DIPC/appropriate other, have the authority to challenge inappropriate practice and inappropriate antimicrobial prescribing decisions

- Have a monthly review of antimicrobial prescribing decisions

- Benchmarking should be used to demonstrate progress in antimicrobial stewardship

Similarly this will be the same for our NMPs and OOHs prescribing.

Further guidance was published in August 2015 by NICE. The IPC team and MMG have produced the following table of assurances:

NICE NG15 (August 2015)	Standard	Evidence
1.1.16	Encourage and support prescribers only to prescribe antimicrobials when this is clinically appropriate.	• There are SOPs and an approved formulary in place to treat common infections seen in MH inpatient settings • Education on AMR and prescribing is included in all training, including Induction, Essential training and to junior doctors intakes

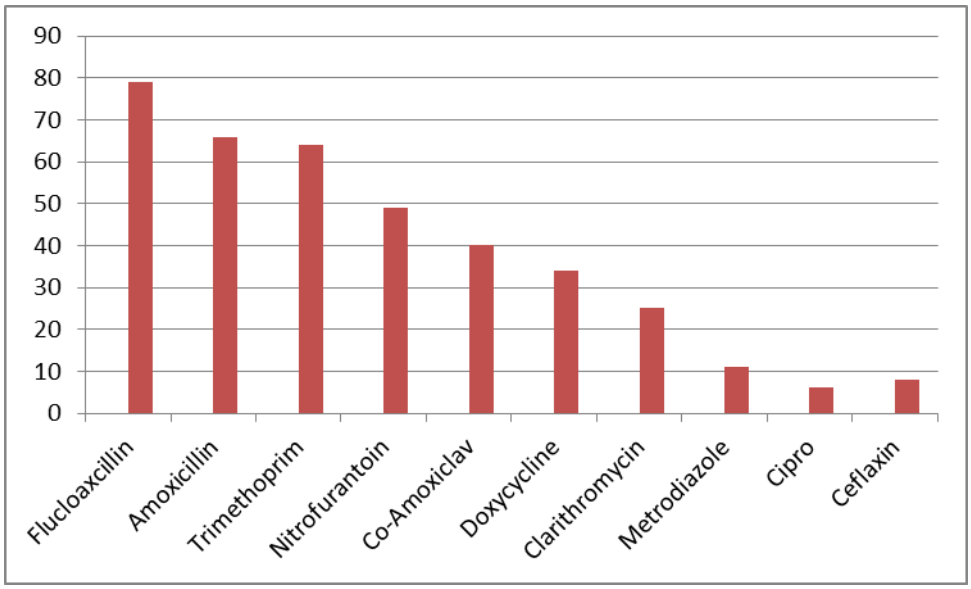
		• The IPCT and our pharmacy colleagues monitor all prescribing charts and data is analysed monthly and collated
1.1.19	Consider developing local systems and processes for peer review of prescribing. Encourage an open and transparent culture that allows health professionals to question antimicrobial prescribing practices of colleagues when these are not in line with local (where available) or national guidelines and no reason is documented.	• Every AM prescription is checked for rationale, compliance with formulary, sensitivities or Microbiologist advice • Where any gaps are identified, these are challenged by the IPC and/or pharmacy team and datix where necessary • Shared learning and communications are utilised where appropriate • The five following categories' are check for compliance against each AM prescription: • *Allergies documented on medication chart* • *Follows antimicrobial formulary/micro advice* • *Indication documented on medication chart* • *Indication documented on carenotes* • *Stop Date indicated on medication chart*
1.1.20	Encourage senior health professionals to promote antimicrobial stewardship within their teams, recognising the influence that senior prescribers can have on prescribing practices of colleagues.	• Pharmacy colleagues, the IPCT and NMP leads promote AM education and related competencies to staff at education events • The importance of AMR and prudent prescribing is recognised by our chief pharmacist, medical directors and consultants, medical and nursing staff
1.1.23	Health and social care practitioners should support the implementation of local antimicrobial guidelines and recognise their importance for antimicrobial stewardship	• The CWP AM formulary is distributed to all new starters (prescribers). It is available on the CWP intranet and as hard copies in all clinical areas where prescribing takes place. • The CWP AM formulary is agreed when consideration has been given to local advice and guidelines recognising regional resistance
1.1.27	For patients in hospital who have suspected infections, take microbiological samples before prescribing an antimicrobial and review the prescription when the results are available.	• Diagnostic sampling is encouraged prior to any AM prescribing where possible • Where this is not possible, prescribing is Oral, the shortest effective course and the most appropriate dose

18.1 Inpatient Services antibiotics audit 2015/16

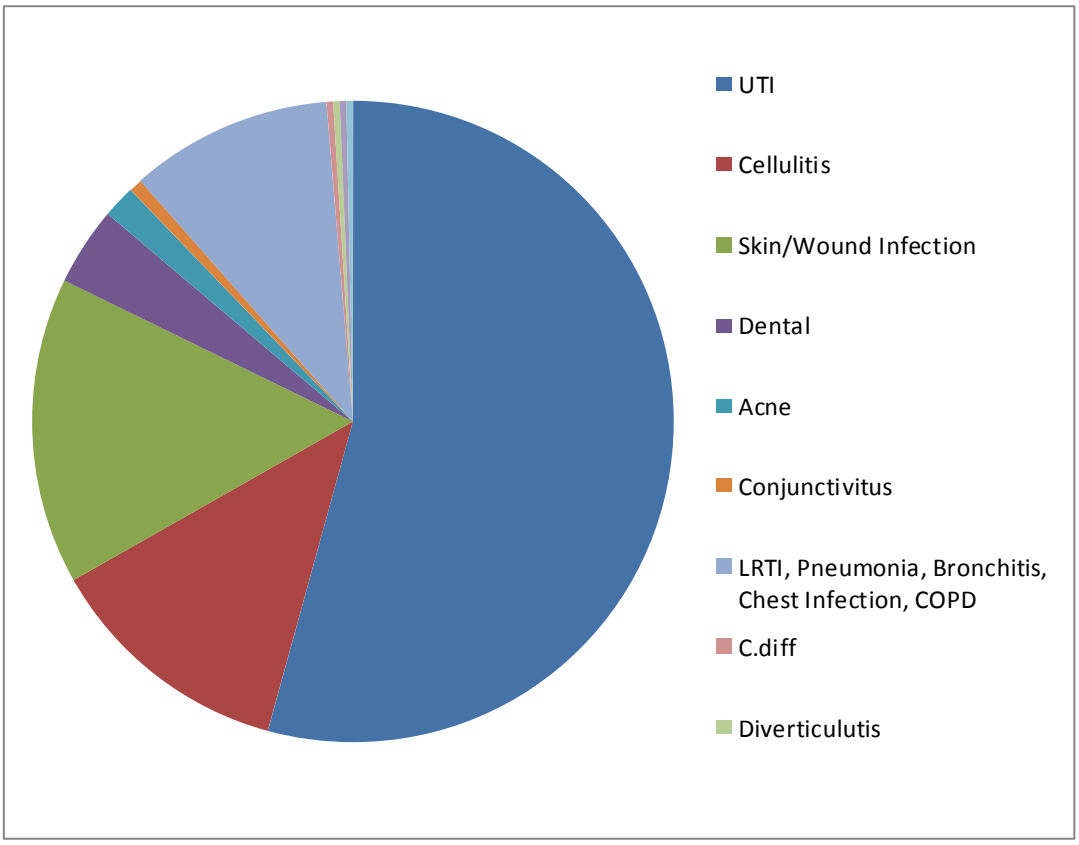
Since April 2015 the IPCT has monitored and responded where necessary, to every antimicrobial prescription with all our inpatients as a benchmark towards our commitment to the national antimicrobial strategy 2013 – 2018

Q2 saw the highest prescribing for UTI's which reflects the activity within the IPCT regarding dehydration and the numbers of multi resistant (ESBL) UTI's. Prescribing within Q3 shows the highest for respiratory infections (Oct, Nov, and Dec).

Top Prescribed Antibiotics Q1-Q4 2015-2016



Top Reasons for Prescribing Antibiotics Q1-Q4 2015-2016



In 2015/16, CWP continued to use the West Cheshire Antimicrobial prescribing guidelines for use within both in-patient and physical health community services, and the in-patient audit criteria is being reviewed to include the antimicrobial stewardship principles of TARGET.

18.2 West Physical Health antibiotic prescribing 2015/16

Antibiotic prescribing activity in CWP West Physical Health is primary care based and as such is a different healthcare setting to secondary care mental health. Prescribers follow current NHS West Cheshire antibiotic guidelines v1 which are currently under annual review. Prescribing is reviewed quarterly using online ePACT data from the NHS Business Services Authority (NHSBSA). The prescribers are:

- Out of Hours (OOH) service – A mix of medical (GP) and nurse independent prescribers (NMP)
- Community Matrons – nurse independent prescribers (NMP) based in the community

Addressing healthcare-associated Clostridium difficile infection remains a key issue on which NHS organisations have been mandated to implement national guidance that includes restriction of broad spectrum antibiotics, and in particular second and third-generation cephalosporin's, quinolones and clindamycin

CWP West Physical Health antibiotic benchmarking is currently measured against one local and national measure:

- Local - compliance with NHS West Cheshire antibiotic formulary.
- National comparators:

Prescribing comparator "Cephalosporins and quinolones % items" This is defined as "the number of prescription items for cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial items". Cephalosporins and quinolones have a higher propensity to cause *Clostridium difficile* associated disease. Prescribing of these antimicrobials cannot

be totally eliminated due to sensitivities and resistance, so the target is to keep usage as low as possible and in line with West Cheshire CCG and national levels.

CWP has continued to prescribe at a level below the national average for these medications and it's OOH Service and NMP's have maintain a minimum 98% compliance with formulary each quarter.

19. Estates Department contribution to the IPC work programme

Acting Associate Director Estates & Facilities

Estates department activity is essential in delivering the IPC agenda, and is delivered under the principles outlined in two main documents:-

1. Health Building Note 00-09 (Department of Health, 2013 -which supersedes and replaces all versions of Health Facilities Note 30) and covers the importance of a clean, safe environment for all aspects of Healthcare.

2. Health Technical Memorandum 04 01, The Control of Legionella, hygiene, "safe" hot water, cold water and drinking water systems." Part A: Design, installation and testing and Part B: Operational management. (Department of Health (DOH) 2006). CWP's 'control of Legionella' closely adopts the requirements of the above HTM.

Estates Department are also currently implementing amendments as required to our management of this issue in light of Approved Code of Practice L8 4th edition and HSG 274 Part 2 both of which were published in April 2014.

The key areas for noting are summarised below.

19.1 Legionella compliance with legislation

The control of legionella is covered by the legal requirements of the Health & Safety at Work Act 1974 concerning risks from exposure to legionella and guidance on compliance with the relevant parts of the Management of Health and Safety at Work Regulations 1999.

Legionella is managed and controlled by the estates department, following CWP policy, IC 17. The Estates department continues to employ the services of *ZetaSafe Ltd*, who provide professional *legionella* services and undertake *legionella* risk assessments on Trust properties where required following significant infrastructure changes or when new premises are acquired. The Estates Department has written a site specific scheme of control for each inpatient premises which reflects the initial ZetaSafe risk assessment. This service also provides for provision of internet based *legionella* database storage and reporting for statutory test results on ZetaSafe2. There is also a three monthly review of test results, control measures and procedures to ensure compliance with current legislation and these results are published at the Infection Prevention Control Sub Committee.

Estates Operational Service continually undertake *legionella* tests throughout the Trust estate, during April 15' – March 16' at total of 18583 temperature tests were undertaken, with 94.4% of tests being within specified limits for the last 12 months. A test is classified as outside of specified limits if it is as little as 1/10 of one degree above or below the set parameter. The majority of out of specification readings are corrected within a day. The annual test result report records an overall compliance level of 94.4% which is above the department's target. 5.4% of tests recorded did not meet the required standard and therefore automatically triggered remedial work to ensure compliance moving forward.

19.2 Capital programme Works

Whilst the capital programme only includes limited projects, specifically aimed at addressing IPC, all new build and major refurbishment projects are designed in full accordance with the latest Building

Regulations, and British Standards together with the latest HTM guidance specifically in relation to Infection Prevention and Control and with consideration to the IPC audits.

Standard details include:

- PVC wall cladding in lieu of tiles.
- Sheet vinyl flooring with coved skirting and welded joints.
- HTM64 sanitary ware and brassware.
- Solid core laminated service panelling to conceal pipe work.
- Suitable vinyl covered furniture.

All projects, both new builds and refurbishment, include advice from the IPC team which reflects the latest Health Building Note 00-09 (Department of Health, 2013) which states *'the infection prevention and control (IPC) team should be consulted throughout every stage of a capital project and their views taken into account.'*

The end of year position for 2015/16 capital programme was recorded at £13m - specific projects to note include:

- Continuation of CAMHS new build £12m
- Backlog maintenance programme £120k
- Springview First Floor Ward refurbishment £0.5m

Estates service have also agreed a recurring planned replacement programme for ward based washing machines, dryers , dishwashers and EBME equipment in order to enable finance to plan for this recurring expenditure and avoid periods of downtime when these facilities are unavailable to wards due to breakdown.

19.3 Physical Health West capital and operational revenue programme

In response to CWP IPC audits of Physical Health West properties, a further £30k was invested from the minor works budget to address specific action points.

20. Cleaning Services

CWP operational cleaning services are led via the Infrastructure services structure, currently led operationally by the deputy head of facilities, who are responsible for implementing the trusts cleaning strategy. CWP Facilities have recently undergone a restructure in line with the departmental review, the aim of which was to increase efficiency within the department, implement smarter ways of working and maintain the highest standards of service provision based on a customer focused approach.

The Facilities Manager function has Facilities teams in each locality that report through a structure of supervisory staff members, who are responsible for the co-ordination of services and monitoring of standards in all trust areas in line with national standards of cleanliness.

CWP Facilities services are predominantly provided in-house, this helps to ensure that services provided by the FM team are linked to the needs of clinical services. There are a number of locations within CWP that are outsourced and are managed by the FM senior management team. The current outsourced provider and the areas they cover are highlighted below:

Current provider – West Cheshire Cleaning services Tender start date: 01/04/2016 Contract review and retender due: 01/10/2016 – new contract start date 01/04/2017
Areas covered by contract:

- Marsden House
- St Anne's Street
- Sycamore House
- Westminster Clinic
- Hawthorns centre
- Vale House
- Chester eating disorders service (Gateway)
- The Oaks office park
- Stella Nova
- Gordon House
- Princeway

20.1 Monitoring Arrangements for CWP in house cleaning service

To monitor compliance in relation to cleaning standards, CWP operate a monitoring system that covers all 49 factors as set out in the national standards of cleanliness 2007 approved code of practice.

CWP uses a system called MiC4C to perform these audits, for the past year this system has been under review linking to Micad (Estates building management software). This has meant that paper audits have been completed for all Trust areas and verbal updates have been provided via the IPC subcommittee. For FY 2016/2017 CWP Facilities is looking to invest in portable IT devices to enable supervisors to complete computerised audits in each building/department.

The move to this new system will enable any failures to be dealt with in a more efficient way. The overall targets and achievements for cleanliness are listed below (again based on NSC risk ratings):

RISK LEVEL	TARGET RESULT (as set out by National Patient safety agency)	CWP Result
Very High Risk	95%	99%
Significant Risk	85%	95%
Low Risk	75%	90%

This information is taken from an average of all paper audits completed within 2015-2016.

Overall the facilities management team cleanliness monitoring is supported by monthly Modern Matron walk-rounds that are attended by a senior member of the FM team to undertake a joined up approach with clinical services and address any issues patients or clinicians have with the Facilities services including the environment, this is then actioned by the relevant departments.

CWP FM attend all inpatient IPC audits, areas for action are addressed mostly at the time of audit, any that can't be addressed immediately are added to FM work plan following the inspection. For the buildings/areas where FM does not attend, when the audit report is sent out a member of the Senior FM team will forward any actions to the supervisor responsible for the building/area for action. This approach ensures that any areas of non-compliance are addressed quickly and efficiently.

Overall the Facilities teams have a good working relationship with all members of the IPC team, taking a working collaboratively approach to ensuring CWP's environments meet all required standards.

The annual statement on the Facilities aspects that relate to IPC agenda would be incomplete without the mention of an issue that is present on both the IPC risk register and Facilities departmental risk register. CWP are currently recording compliance with the national standards of cleanliness, this position is not sustainable and moving forward it is likely that standards will drop in High Risk areas

and this will be closely monitored. Due to considerable financial constraints - CWP's Facilities equipment replacement programme has been withdrawn for 15/16 FY and again in 16/17 FY.

20.2 Waste Management

Following the successful roll out of shared waste and recycling stations at 5 Trust locations; Chester, Ellesmere Port, Wirral, IAPT Sefton and IAPT services Southport in 2015, the CWP recycling waste project was rolled out in spring 2016 to a further 5 sites in East Cheshire and Central Cheshire. The project has resulted in increased waste recycling and segregation to 97% (reported by our contractors 2015-16).

The introduction of central recycling points in high concentration staff areas in CWP has seen a number of benefits. Staff are encouraged to participate in recycling and separating at source all items of general waste. The efficient system has a number of benefits including:

- Staff can clearly see how they contribute to the Trust's environmental objectives through recycling and by separating their own waste staff can better understand the environmental value of recycling.
- Domestic time has been freed up from emptying excessive numbers of bins to allow more cleaning time
- Risk of back problems amongst domestic staff from repetitive bending is reduced and staff are able to increase their physical activity by walking to the waste stations

20.3 Waste Auditing

The CWP Waste audit system is designed to assess compliance with the requirements of Department of Health guidance document Safe Management of Healthcare Waste and to also ensure that waste segregation standards meet the requirements for waste handling and storage. The Trust waste policy was updated December 2015 and incorporates a flowchart quick reference guide for all staff.

A programme of 6 monthly waste audits was completed in 2015. The Waste audits are underpinned by a Waste Audit Schedule which also notes any issues or incidents and outcomes.

Waste audits form part of a planned programme of waste management and any issues or outstanding actions is followed up by Waste Manager and or Facilities team. The Infection prevention and Control Team are included in any communications. Where a new service is introduced, a full "Pre-acceptance" waste audit is carried out by the Waste Manager to assess all types of waste and disposal methods. Thereafter audits are completed as part of the cleanliness monitoring by domestic supervisors at all sites. Audits are saved onto the Environment and Waste system and issues followed up within 24 hrs with appropriate actions logged on the Audit Schedule.

Some of the actions from the 2015 – 2016 audit programmes have included addressing the following risks:

Inappropriate waste disposal – packaging and paper towels disposed of in clinical waste bins
Not displaying posters correct disposal procedures
Sharps bins temporary aperture closure not in place
Storage of items in non-appropriate non patient areas (Waste holds
Unlocked bins in outside areas
Waste Compound not secured
Contractor issues- missed collections and non-delivery of sharps bins

21. Patient-led Assessment of the Care Environment (PLACE)

All PLACE inspections are complete for 2016, the standards and way in which the inspections were conducted has improved dramatically. The results will be published nationally via the NHS information centre in August /September 2016.

The PLACE assessments cover the following areas:

- General Environment condition
- Environment cleanliness
- Food & Hydration – including – Quality/Taste/Temperature
- Privacy & Dignity
- Dementia friendly assessment

Overall the inspections this year have been excellent; the inspection teams are made up of trust PPI reps, Trust governors and external agencies, for 2016 CWP has had good representation from Health-watch in all areas of the Trust footprint.

Specific comments made by patient reps on 2016 visits are below:

- The unsuitable nature on Millbrook unit was noted, however comments were that although CWP were "making the best" of the environment, unfortunately it was observed that the environment did not match other areas of the Trust.
- The introduction of "Mood Boards" developed by our capital projects team, are "fantastic", "really break up the clinical feel of ward environments", and "make ward areas feel more homely".
- Food provided to ward environments is of an "excellent standard"
- Standards of cleanliness on ward areas "are excellent and are a credit to CWP".
-

Any areas that received a fail or qualified pass were added to the Facilities department action plan, any areas that required input from the Estates management team have been added to Micad for addressing or reported to capital projects team for adding onto their work plan.

22. Conclusion

Infection prevention and control remains a priority for CWP. The IPCSC and IPCT continue to maintain and improve on the application, conservation, and development of IPC standards. The trust is committed to working towards excellence in IPC practice as a best provider, considering our contractual obligation to our external commissioners, CWaC, see Appendix One.

This report highlights the partnership working and continuous improvements last year and the work programme for 2016/17 is set out below for Board approval Appendix Three.

23. Recommendations

The Board is asked to approve the Infection Prevention and Control Annual Report for 2015/16 and the work programme for 2016/17.

24. Appendices

Appendix One

Cheshire West and Chester IPC Annual Report 2015/16

Appendix Two

Glossary

Appendix Three

IPC Work programme 2016/17

25. References and associated documents.

References and associated documents

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Trustwide Safeguarding Annual Report 2015/16
Agenda ref. no:	16/17/40
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	27/07/2016
Presented by:	Avril Devaney, Director of Nursing, Therapies and Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	Yes
Risk 2: Safeguarding	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
35T	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

The purpose of this report is to provide Cheshire and Wirral Partnership (CWP) Board with assurance of safeguarding responsibilities in relation to key legislation and guidance for both children (including children in care) and adults.

It includes all aspects of safeguarding activity and performance for which CWP is responsible for during April 2015 - March 2016.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The report provides assurance of how the Trust has met its responsibilities and requirements a regulated provider under Regulation 13 of the Health and Social Care Act 2008, The Care Act 2014, the Children Acts of 2004 and 1989, the statutory guidance Working Together to Safeguard Children, 2015 and Promoting the Health of Looked After Children, 2015.

Assessment – *analysis and considerations of options and risks*

The report is structured to provide the overarching Trustwide perspective on safeguarding responsibilities followed by three sections, which reflects performance and activity within each of the CWP localities – West, Central & East and Wirral. Each locality has its own focus on key priorities that are informed by both the services provided in the locality and the priorities of the Local Safeguarding Boards. The report also includes a review of performance against the previous year's priorities. The final section of the report sets out the objectives for the forthcoming year.

The full report is included at appendix 1.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors are recommended to **approve** the report.

Who/ which group has approved this report for receipt at the above meeting?	Avril Devaney, Director of Nursing, Therapies and Patient Partnership
Contributing authors:	Satwinder Lotay, Head of Safeguarding

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
35T	Trustwide Safeguarding cub committee	July 2016

Appendices provided for reference and to give supporting/ contextual information:
Provide only necessary detail, do not embed appendices, provide as separate reports

Appendix no.	Appendix title
1	Trustwide Safeguarding Annual Report 2015/16

16_17_40 Appendix 1

CWP Safeguarding Adults and Childrens (including Children in Care) Annual Report 2015/2016

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3. **Trustwide Activity and Performance**

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   - **3.2 Safeguarding Governance Arrangements**
   - **3.3 Board Assurance Framework- Risk Register**
   - **3.4 Safeguarding Adult Activity**
   - **3.5 Safeguarding Children Activity**
   - **3.6 Safeguarding Supervision**
   - **3.7 PREVENT Activity**
   - **3.8 Mental Capacity Act and Deprivation of Liberty Safeguards**
   - **3.9 Domestic Abuse Activity**
   - **3.10 Safeguarding & Looked After Children Training**
   - **3.11 Serious Case Reviews / Learning Reviews for Children**
   - **3.12 Serious Adult Reviews/ Domestic Homicide Reviews/ Learning Reviews for Adults**
   - **3.13 Inspections/ Reviews**
   - **3.14 Assurance Process and Audits**
   - **3.15 Progress on Key Objectives for 2015/16**

4. **Locality Activity and Performance**

   - **4.1 Central and East Locality**
   - **4.2 West Locality**
   - **4.3 Wirral Locality**

5. **Trustwide Objectives for 2016-2017**

6. **Conclusion**

Appendix A CWP Membership of Safeguarding Boards and Subgroups

1.0 Purpose of the Report

The purpose of this report is to provide Cheshire and Wirral Partnership (CWP) Board with assurance of safeguarding responsibilities in relation to key legislation and guidance for both children (including children in care) and adults. It includes all aspects of safeguarding activity and performance for which CWP is responsible for during April 2015- March 2016.

The report provides assurance of how the Trust has met its responsibilities and requirements as a regulated provider under Regulation 13 of the Health and Social Care Act 2008, The Care Act 2014, the Children Acts of 2004 and 1989, the statutory guidance Working Together to Safeguard Children, 2015 and Promoting the Health of Looked After Children, 2015.

2.0 Summary

CWP provides a diverse number of services across the whole age spectrum, from universal to regional specialist services. These include mental health inpatient and community services, learning disability services, substance misuse services, child and adolescent mental health services (CAMHS), adult physical health services and children's public health services. These services are commissioned by Clinical Commissioning Groups (CCGs), NHS England or Local Authority Public Health Commissioners.

Safeguarding activity has continued to increase across all public sector services. During the last year, health services have responded to a number of policies, strategies, inquires and initiatives. These have included for example, the implementation of the reporting mechanisms for Female Genital Mutilation, responding to the implementation of the Modern Slavery Act, refining the PREVENT training and participating in CHANNEL panels (as part of the Government Terrorism strategy CONTEST). The recognition and responses to domestic abuse has continued to grow and the Multi-Agency Risk Assessment Conference (MARAC) process continues to be refined and reviewed. The Child Sexual Exploitation response within the various local authorities has become more established and the activity in this area also continues to grow.

Central for CWP Adult Safeguarding has been the implementation of the Care Act 2014 that came into practice on 1st April 2015. CWP has responded to the requirements brought about by this legislation in relation to co-operation with Local Authority processes, engagement with Safeguarding Adult Boards and ensuring CWP is able to respond to requests from the Local Authority to undertake management reviews and investigations as requested. CWP has responded to a proliferation of requests to adult case review consideration across all local authorities in which CWP delivers services. The continued implementation of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) has further impacted on CWP activity over the last year.

During 2015/16 CWP has been involved in tendering processes both in bids for new services and for bids to retain existing business. The mobilisation of new services and the exiting of contracts have had an impact on safeguarding activity and demand across the Trust. The impact of service provision moving to different health Trusts and sometimes to non-NHS providers, along with different commissioned services within the Local Authorities has opened new areas of challenge to ensure safeguarding practice is maintained across organisational boundaries. This will continue to be an area where safeguarding risk needs to be identified and mitigated as the service provision landscape alters. CWP will continue to work closely with Local Safeguarding Boards and Commissioners to ensure safeguarding practice remains robust across different providers.

The Standard NHS contract incorporated into contracts with CCGs is monitored through the development and completion of Safeguarding Assurance Frameworks. The indicators for these frameworks have become more established within contracts. There has been increased scrutiny of indicators to monitor performance from CCGs and Designated Nurses for both adults and children.

Central to effective safeguarding practice has been through ensuring staff are trained and competent, and this has been reflected in the contracting frameworks over the last year. The competency framework for safeguarding children has been developed over 2015/16 to ensure appropriate adult services are also gaining competency at Level 3, as stipulated in the 'Safeguarding Children and Young people: roles and competencies for health care staff' Intercollegiate document (2014) and appropriate clinical staff are competent to the level of their role requires as guided in the 'Looked After Children: Knowledge, skills and competencies of health care staff' Intercollegiate document (2015). CWP safeguarding service have launched a quarterly safeguarding newsletter as well as producing safeguarding briefings to ensure CWP staff are regularly updated on the changing safeguarding landscape in addition to producing shared learning bulletins to share the learning from safeguarding audits and case reviews.

Safeguarding governance arrangements and practice within CWP continue to develop in an integrated way. This has ensured that the 'Think Family' approach continues to be embedded, particularly across shared areas of practice such as domestic abuse and substance misuse. As the Safeguarding Adults Boards have moved onto a statutory footing under the Care Act, CWP will continue to work closely with the Boards to ensure best practice from the Children's Boards and engagement with sub-groups is maintained. CWP is in a position to share learning and best practice across a number of Safeguarding Boards. CWP actively engages with young people to ensure their voice is
heard in shaping key services. This year CWP participated in the national "Takeover day" in November.

The report is structured to provide the overarching Trustwide perspective on safeguarding responsibilities followed by three sections, which reflects performance and activity within each of the CWP localities – West, Central & East and Wirral. Each locality has its own focus on key priorities that are informed by both the services provided in the locality and the priorities of the Local Safeguarding Boards. The report also includes a review of performance against the previous year's priorities. The final section of the report sets out the objectives for the forthcoming year.

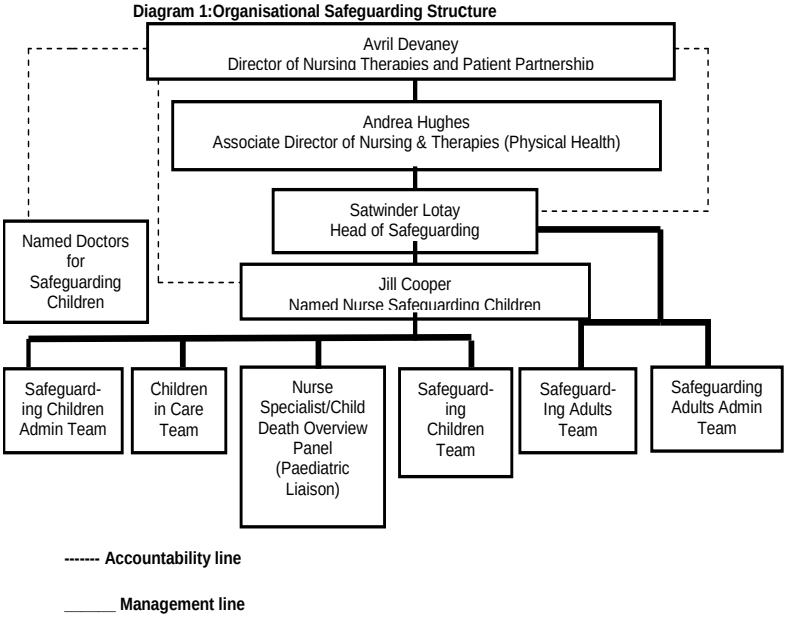
3.0 Trustwide Activity & Performance

3.1 Safeguarding Leadership & Accountability

The CWP Trust Board has an identified Executive Director who leads on Safeguarding for CWP; this is the Director of Nursing, Therapies and Patient Partnership, who champions safeguarding throughout the organisation and represents the Trust on the Local Safeguarding Children's Boards. The Associate Director of Nursing and Therapies (Physical Health), is a member of the Local Safeguarding Adult Boards, supports the Director of Nursing. The safeguarding structure for CWP is shown in diagram 1.

Diagram 1: CWP Safeguarding Structure

Diagram 1:Organisational Safeguarding Structure



------- Accountability line

_____ Management line

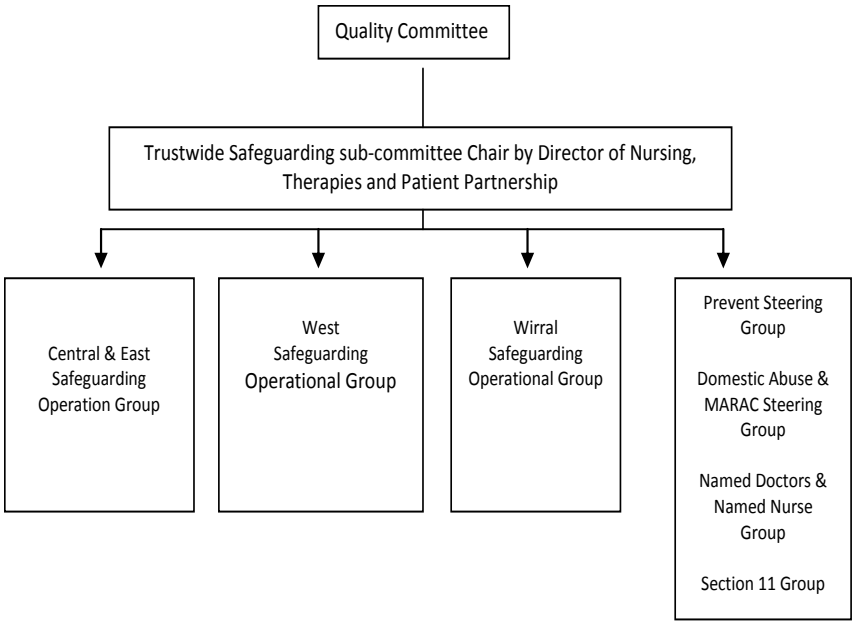
Due to an end of a secondment and an internal promotion, recruitment to both positions of Head of Safeguarding and Named Nurse for Safeguarding Children was undertaken in December 2015 and February 2016 respectively.

The Named Nurses and Named doctors are responsible for ensuring policies, supervision and training are in place and compliant with national guidance and procedures. The Named Nurses are members of a number of LSCB and LSAB sub groups (supported by the nurse specialists).

3.2 Safeguarding Governance Arrangements & Assurance

The Quality Committee has established the Trustwide Safeguarding Sub-committee to provide assurance that Safeguarding responsibilities are met through the activities of the Trust in line with the terms of reference for the sub-committee. The safeguarding governance structure is illustrated in Diagram 2. The Sub-committee integrates both children and adult safeguarding including Looked After Children and Domestic Abuse. This sub-committee monitors and reviews action plans, approves safeguarding policies for both adults and children, monitors the Trust safeguarding audit programme, monitors compliance with Safeguarding Assurance Frameworks and training programmes including compliance levels. It also reviews the work of the Local Safeguarding Boards and sub-groups via update reports and briefings.

Diagram 2 CWP Safeguarding Governance Arrangements



The Trust has established a number of groups that report into the Trustwide Safeguarding Sub-committee (see diagram 2). These groups report risks and exceptions to the Trustwide Safeguarding Sub-Committee.

CWP provides assurance to commissioning CCGs and Designated Nurses for both adults and children via completion of Safeguarding Assurance Frameworks. They include data submissions in relation to training, supervision and safeguarding activity.

Every year, the annual self-assessment for both adult and children's safeguarding is undertaken and submitted for scrutiny to the CCGs. Quarterly Safeguarding Assurance meetings between CWP and CCGs provide opportunity for scrutiny and challenge, to identify areas of risk and areas of good practice.

3.3 Board assurance Frameworks- Risk Register

The risks relating to safeguarding on the CWP Board Assurance Framework are reviewed, mitigated, and monitored by the Trustwide Safeguarding Sub-committee. The risk remained unchanged since it was re-modelled in June 2015 to reflect the need for positive assurance that safeguarding practice is being implemented. The risk level has remained the same. It was agreed in the Trustwide Safeguarding Sub-committee that the risk will be re-modelled to reflect the dip in level 3 safeguarding children training compliance following the introduction of a new training needs analysis. This was approved in March 2016.

3.4. Safeguarding Adult Activity

CWP Nurse Specialists for Safeguarding Adults receive enquiries for advice and support from CWP staff in relation to safeguarding issues. The outcome of these discussions may result in the concern that has been raised, being managed locally within the service or in a referral to the appropriate Local Authority safeguarding services.

Diagram 3 illustrates that CWP has seen a 4% increase in the number of enquiries/contact made to the Adults Safeguarding Team in 2015/16. CWP welcomes this increase in contact with the Nurse Specialists as it demonstrates that staff are identifying and seeking advice on management of concerns in relation to safeguarding practice. This demonstrates CWP staff recognises adults at risk and reflects a high patient safety culture, with staff implementing appropriate intervention and care planning to ensure the service users safety and wellbeing.

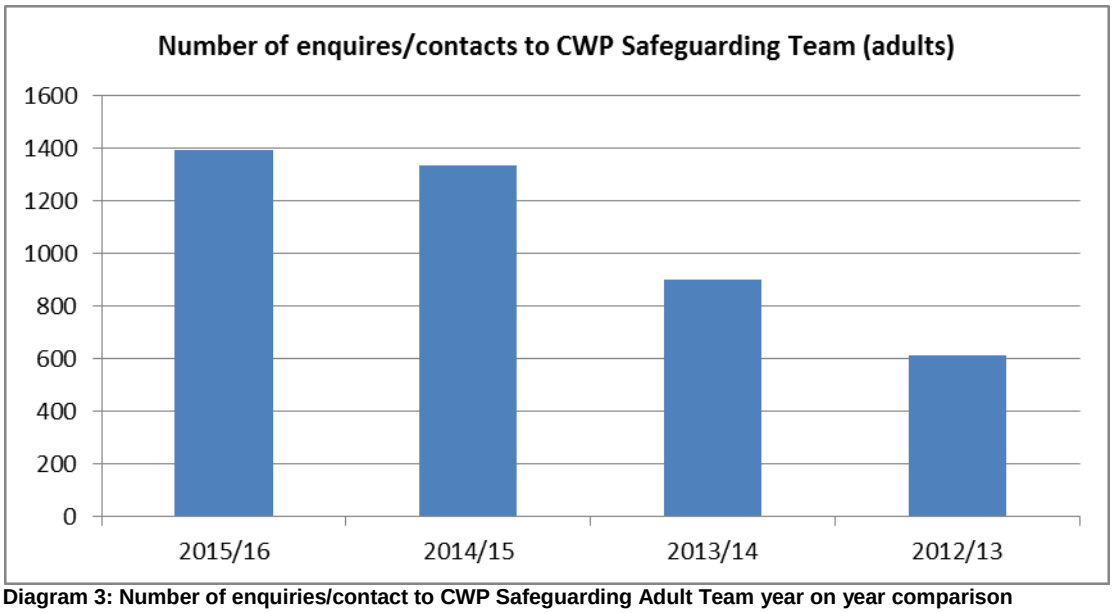


Diagram 3: Number of enquiries/contact to CWP Safeguarding Adult Team year on year comparison

There has been an insignificant decrease in the number of referrals made by CWP to Local Authority Safeguarding Services, with 74 made for 2015/16 year compared with 78 referrals made the year before. This may be in part due to the continuing rise of contacts from CWP staff with the Safeguarding Adult Nurse Specialists thus leading to the concerns being managed locally within the service, resulting in effective safeguarding measures being put in place to safeguarding the adult at risk.

3.5 Safeguarding Children Activity

There has been an increase in the numbers of practitioners attending common assessment framework/ team around the Family (CAF/TAF) meetings across all services especially from adult mental health services and substance misuse services, which strengthens multi-agency decision making in relation to safeguarding children. The data reporting on CAF/ TAF is on number of practitioners involved rather than cases and averages around 121 practitioners involved per month in CAF activity. The number of CAF / TAF initiated by CWP services has dipped this year but this could be explained by the sharp increase in child protection activity (see diagram 4)

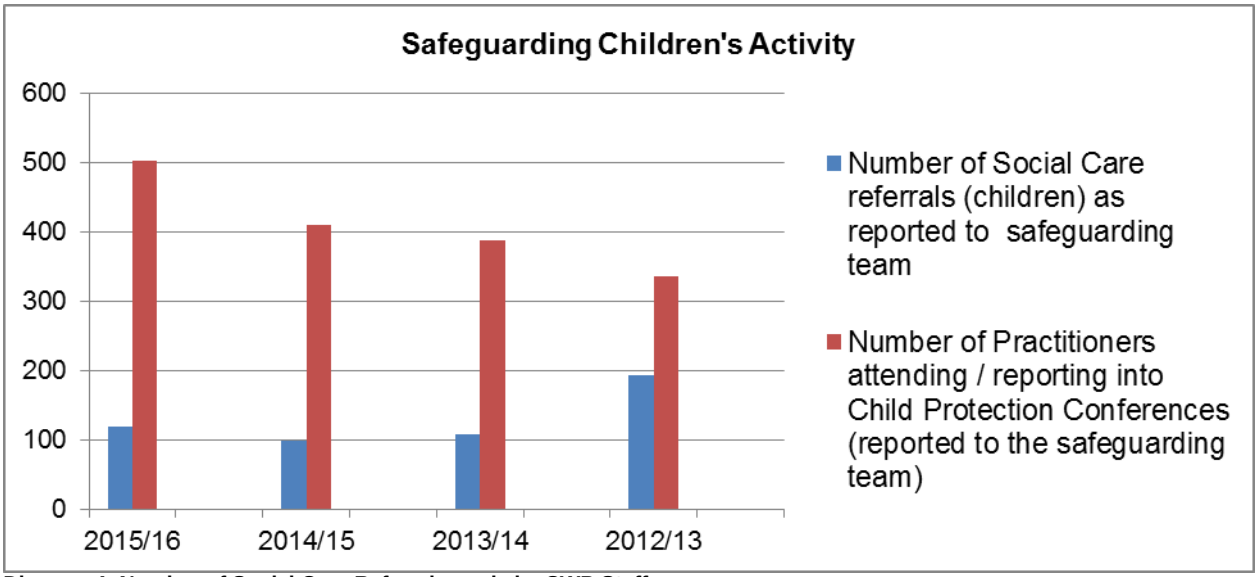


Diagram 4: Number of Social Care Referrals made by CWP Staff and Number of child protection conferences attended/ reported into – a Year on year comparison.

The number of children social care referrals has increased this year as well as the number of Practitioners attending / reporting into child protection conferences. This reflects the increase in

child protection activity within the local authorities as well as the safeguarding team strengthening the relationships across all local authorities to ensure all notifications of child protection case conferences are received by the safeguarding children team. This has had an impact on the team in ensuring practitioners are receiving safeguarding supervision in a timely manner.

There has been a significant increase in the number of court report requests in relation to Public Proceedings with the safeguarding children team supporting 55 practitioners with their court statements. The Named Nurse for Safeguarding has also supported two CWP practitioners in providing evidence in court

The Safeguarding Children Team continues to be actively involved with the Child Sexual Exploitation (CSE) agenda across all the localities. During 2015/16, the Nurse specialists for Safeguarding Children attended 33 CSE operational meetings compared with 30 the year before. The Nurse Specialists gather information on cases and attend CSE operational groups in each locality. Staff in the localities have been briefed on the referral and process regarding CSE. It is already evident that as the awareness of CSE is increasing, that this area of safeguarding children and young people work is expanding. The Trust actively participated in the National CSE day in March 2016 and a list of activities to increase awareness of CSE is highlighted in Box 1.

Box 1:Summary of CWP CSE Awareness Activity

- Communications tweeted pledges from CWP staff throughout the day included these from Trustwide Safeguarding meetings, Locality Safeguarding meetings, and many teams throughout the trust.
- Safeguarding Practice Leads raised awareness in their teams in the build up to CSE day
- There were displays in the waiting area and staff were on hand to answer queries from service users/visitors in some services across the trust.
- Safeguarding Newsletter included an article raising awareness about the day, signposting to partner services and resources for both practitioners and service users/families
- CWP intranet had a banner headline throughout the week so that staff were alerted to the date when "logging on" to the system, therefore going to a wide audience
- CWP Essentials had an article on the day
- Discussed at Locality meetings so that Management could cascade to the teams
- Staff were encouraged to use the footnote to raise awareness on CSE on email communication

3.6 Safeguarding Supervision

Safeguarding Supervision is available for all staff groups across CWP. All the Nurse specialists within the Trust have completed an accredited safeguarding supervision course. The Family Nurse Partnership (FNP) has a FNP Supervisor who provides supervision for that team. A named safeguarding nurse specialist provides advice, support and supervision to the FNP supervisor. The service has discussed 52 cases with the safeguarding nurse specialist.

During the past three years a model of case supervision has been utilised more frequently whereby a number of practitioners working within the same family/household come together to review, assess and critically analyse what is happening for the individual child/ young person/ vulnerable adult concerned. It has also given practitioners insight into each other's roles and expertise. The safeguarding children team has seen an increase by 104% from the previous year delivering 793 individual safeguarding supervision sessions. Many of the sessions included more than one case being discussed.

An experienced Nurse Specialist for safeguarding children and Named Nurse for Safeguarding children have provided 35 safeguarding case supervision and intensive support in ensuring timely escalation and appropriate safeguards are in place for patients receiving a service from Tier 4 CAMHS.

The Safeguarding Adult service has provided safeguarding supervision on request to a number of practitioners. The system to capture this data will be strengthened to ensure safeguarding adult supervision is captured more robustly.

Following the successful pilot in Central and East locality the safeguarding practice link (SPL) programme, has been rolled out across all of the trust. The SPLS' role is to promote an awareness

of safeguarding issues within their team and to signpost their colleagues in respect of their safeguarding concerns and practice as well as promoting safeguarding supervision. Within the past year, the safeguarding children team have facilitated 22 SPL group supervision sessions across the Trust. Currently the SPL programme has had a focus on safeguarding children. This will however be expanded to include safeguarding adults in the forthcoming year.

3.7 PREVENT Activity

The Prevent Wrap training for CWP staff is mandatory and has continued to be delivered throughout 2015/16. The number of approved WRAP trainers has increased to 11 as a result of a number of 'Train the trainer' sessions facilitated by CWP Safeguarding Adult Nurse Specialists. The target to reach 80% compliance has been missed (see Table 1).However, it is envisaged that this will be achieved by end of quarter 2 in 2016-17.

Table 1: PREVENT WRAP Training Compliance on 31 March 2016.

	Requiring level 1 and 2	**Requiring Wrap Level 3 -5**
Number of Staff requiring level 1 and 2	1000	2368
Number of staff who have received training	443 (44%)	1823 (77%)
Overall % staff trained	**67%**	

CWP Safeguarding team are supporting a number of newly established CHANNEL panel meetings across the local authorities. CHANNEL forms a key part of the Prevent strategy. It is a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into terrorism. The Nurse specialists for Safeguarding Adults provide representation on-behalf of CWP at these meetings, with these being held every 2 months in the West and East localities, and every 3 months in the Wirral locality. A total of 9 CHANNEL meetings have been attended by CWP. CWP staff have identified 3 individuals (2 in East Cheshire and 1 in West Cheshire) this year that have been referred in the CHANNEL panels.

3.8 Mental Capacity Act and Deprivation of Liberty Safeguards

CWP has continued to work to strengthen practice in relation to Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS). CWP has developed processes to monitor the application and authorisations for DOLS and has provided guidance and training for staff to ensure a more pro-active approach to MCA. Table 2 provides the training compliance figures for MCA and DOLs training

Training	**% Compliance on 31st March 2016**
Mental Capacity Act DOLS	**83%**

Table 2: Compliance figures for MCA & DOLs Training.

Table 3 sets out the number of standard authorisations granted by Local Authorities and the number of CWP self-authorised urgent DOLS authorisations .There has been a sharp increase in the number of urgent and standard applications made. The data also demonstrates the difficulties the local authorities are facing in meeting the demands of DOLS, as there have only been eight standard authorisations

.

DOLS Figures	**2014/15**	**2015/16**
Urgent authorisations (self-authorised by CWP)	**67**	**81**
Standard applications	**92**	**231**
Standard Authorisations	**55**	**8**

Table 3: Summary of DOLs authorised across CWP

3.9 Domestic Abuse Activity

CWP have continued to support the Multi-Agency Risk Assessment Conferences (MARAC) to ensure all relevant information about a victim, victim's child and perpetrator is shared on the highest risk domestic abuse cases to ensure appropriate risk are managed and appropriate support is

provided. CWP continues to attend monthly MARAC meetings, which operate across Cheshire East, Cheshire West and Wirral.

As the number of MARAC meetings have increased over the last three years, CWP have increased the pool of MARAC representatives to support the safeguarding Nurse Specialists in managing the process. During 2015/16, CWP MARAC representatives have attended 87 MARACS, which have reviewed 2051 cases referred into the MARAC, a significant increase by 13.1% in case numbers. The graphs in diagram 5 and diagram 6 demonstrate this year on increase.

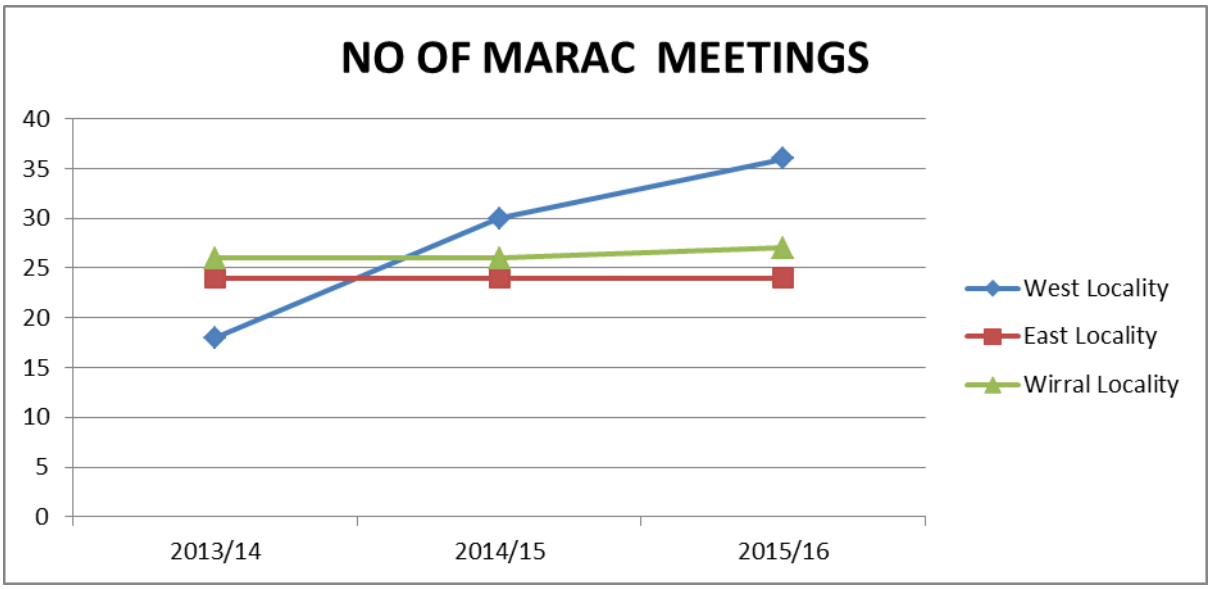


Diagram 5: Number of MARAC meetings across the three localities from 2013-2016.

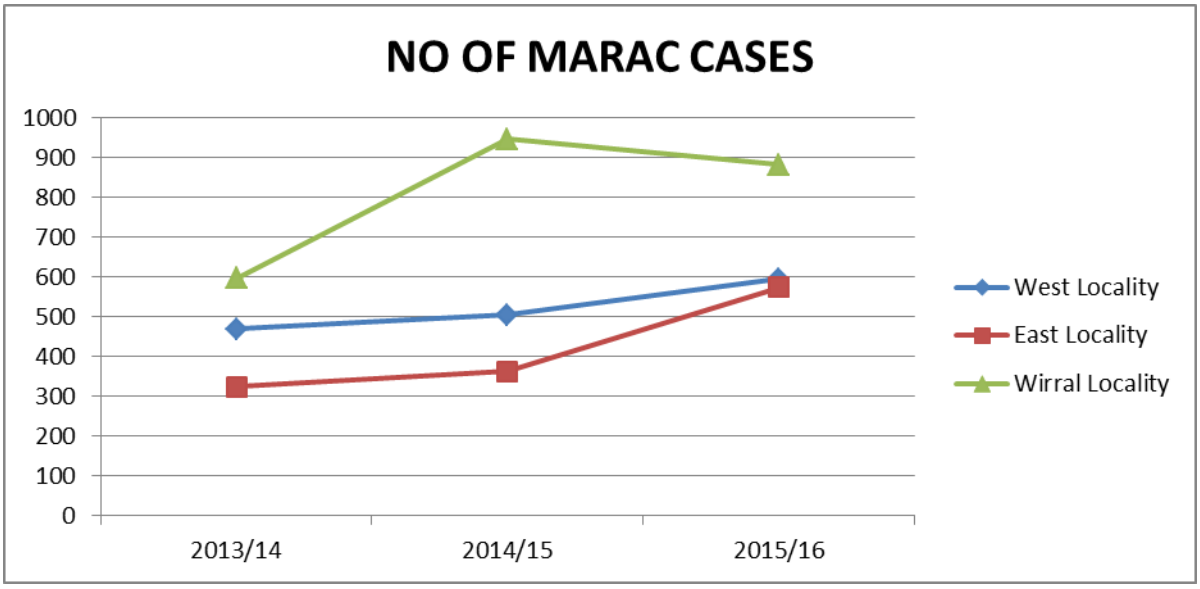


Diagram 6: Number of MARAC cases across the three localities from 2013-2016.

3.10 Safeguarding & Looked After Children Training

A robust training programme for all staff working within the Trust underpins effective safeguarding practice. The Training Needs Analysis undertaken by CWP Education identifies the level of training required for each staff group within the organisation. Safeguarding training is part of the Trust's mandatory training programme. The intercollegiate document, which was revised in September 2015, provides the guidance for the level of training required for each staff group to maintain competence in safeguarding practice. The Training Needs Analysis was therefore reviewed and

amended in response to provide a more blended approach to learning for Level 3 safeguarding children training, and to include the competency requirement to meet the intercollegiate document in relation to Looked After Children.

Training is provided as e- learning packages and as face-to-face sessions delivered by Specialist Safeguarding and Children in Care Nurses. Staff can also access safeguarding training external to the Trust. Content of the external training is reviewed by the safeguarding service.

Compliance with training is monitored by the Trust wide Safeguarding Sub-committee; locality-safeguarding groups are responsible for ensuring compliance rates are maintained at a local level. Compliance levels are reported to CCGs via the Safeguarding Assurance Frameworks on a quarterly basis. The end of year position- March 2016 is set out in the table below. It is important to note for level 3 there are two figures – one based on the old TNA (pre September 2015) and a compliance rate based on the new TNA. Both figures are shown as the compliance is recorded over a three year period (i.e. 18 hours over 3 years) and the effect of the new intercollegiate document is that the cohort of staff now requiring level 3 training has significantly increased.

Table 4: Safeguarding Training Compliance Rates for CWP 2015/2016

Safeguarding Training 2015/16	Trustwide Compliance Rate as at 31/3/16
Level 1 (children and adults includes domestic abuse)	82.4%
Level 2 (children and adults includes domestic abuse)	80.2%
Level 3 (safeguarding children only)	83% (based on old TNA) 67% (based on new TNA)
Level 4	100%

(Please note: Level 6 safeguarding training for board members has been arranged for April 2016).

Table 5: Looked After Children Compliance Rate for CWP 2015/2016

Looked After children 2015/16	Trustwide Compliance Rate
Level 1 & 2	**81%**
Level 3 –Undertaking Quality Health Assessments (Health Visitors, 5-19 and FNP only)	**98%**
Level 4	**100%**

All training is evaluated by participants and below is some of the comments made by practitioners in relation to the level 3 training

From Level 3

" learnt use of vulnerability matrix as helping to evidence use of the pitfalls as part of practice to challenge self"
" I will be more inquisitive and demonstrate courage and competence in my work"
" It challenged my practice"
" The use of DASH/ RIC was helpful- something I will use in practice"
"Increased my awareness of CSE and now aware of tools that can help identify"
" feel more competent involving young people in assessment"

3.11 Serious Case Reviews/ Learning Reviews for Children

There have been two SCR, both commissioned by Cheshire West and Chester LSCB, in which CWP services have been involved. The respective action plans are being implemented, with CWP working with partner agencies to ensure recommendations are progressed. CWP services have actively participated in a number of multi-agency reviews (see Table 4). The resulting Action Plans are reviewed at the most appropriate Safeguarding Locality Group and are overseen and monitored by the Trustwide Safeguarding Sub- Committee. There have been 4 cases where chronologies have been provided for serious case review panels of the LSCBs but did not progress to any level of review. There is one SCR chronology that has been submitted to Wirral LSCB but awaiting the panel outcome.

Shared learning bulletins have been produced and disseminated to all staff across CWP to ensure learning from reviews is shared widely as well as discussing the learning at Trustwide Safeguarding Sub-committee and safeguarding locality groups.

Table 6: Summary of Reviews that CWP Involved with 2015/2016

Type of Review	Local Authority and Board Responsible	Services Involved from CWP
SCR 01/14	CWAC LSCB	Health Visiting and School Nursing
SCR 01/15	CWAC LSCB	School Nursing and CAMHS
Health Agencies review on	Cheshire East LSCB	Adult mental Health (CHMT)
Critical Case review on	Wirral LSCB	CAMHs and Adult mental Health
Single agency Review on	Wirral LSCB	CAMHS

3.12 Serious Adult Reviews/ Domestic Homicide Reviews/ Learning Reviews for Adults

CWP services have actively participated in a number of multi-agency/health agency reviews (see Table 5). There has been one adult Serious Case Review (SCR also referred to SAR) in which CWP were involved during 2015/16 commissioned by Worcestershire LSAB. The resulting action plan has been completed by the respective locality involved. The action plans are reviewed at the most appropriate Safeguarding Locality Group and are overseen and monitored by the Trustwide Safeguarding Sub- Committee. There have been 5 cases where chronologies have been provided for case review panels of the LSABs but did not progress to any level of review. There are 3 cases where it has been identified that it did not meet the threshold for an SAR but the panel agreed the case warranted a multi-agency review which have not been undertaken as yet.

CWP have not undertaken any domestic homicide reviews during this reporting timeframe.

Table 7: Summary of Reviews that CWP Involved with 2015/2016

Type of Review	Local Authority and Board Responsible	Services Involved from CWP
SCR	Worcestershire LSAB	LD Inpatient service
IMR	CWAC LSAB	Community nursing

3.13 Inspections / Reviews

Cheshire and Wirral Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered and licensed to provide services. The Trust has no conditions on its registration. The Care Quality Commission has not taken enforcement action against the Trust during 2015/16. The Trust has participated in 1 investigation by the Care Quality Commission during 2015/16, which was in relation to the following area:

This inspection took place in June 2015, in line with the new inspection framework and a commitment to inspect all mental health trusts by December 2016. The inspection covered 14 core services across the Trust. The overall ratings for the Trust were published in an inspection report published on 3 December 2015.

Routine inspection of core services

Overall rating for services at this Provider	Good
Are Services safe?	Requires improvement
Are Services effective?	Good
Are Services caring?	Outstanding
Are Services responsive?	Good
Are Services well-led?	Good

Of the core services inspected, wards for people with learning disabilities or autism were rated 'outstanding' – which is a rare accomplishment. 10 core services were rated 'good': community-based mental health services for older people; specialist community mental health services for children and young people; wards for older people with mental health problems; long stay/ rehabilitation mental health wards for working age adults; community mental health services for people with learning disabilities or autism; community health services for adults; mental health crisis services and health-based places of safety; child and adolescent mental health wards; community-based mental health services for adults of working age; and end of life care. The services rated as 'requires improvement' were community health services for children, young people and families; acute wards for adults of working age and psychiatric intensive care units; and forensic inpatient/ secure wards. A robust action plan was developed in response to the regulatory actions identified, which was agreed with the Care Quality Commission and subsequently implemented. All actions have been completed by 31 March 2016 as agreed with the Care Quality Commission. A re-inspection is expected during quarter 1 of 2016/17 to review the actions taken, the outcome of which will update the current rating for services at the Trust.

The Trust has also been involved in two OFSTED inspections during 2015/16- Cheshire West and Chester and Cheshire East. Cheshire West and Chester was rated as Good overall and Cheshire East was rated as Requiring Improvement.

3.14 Assurance Process and Audits

The 2015/16 Safeguarding Audit Programme has been completed. The learning themes from these audits are summarised in Box 2.

Box 2: Summary of outcomes from CWP Safeguarding Audits

Safeguarding Children

- The facility to place an alert on the service user record is available and not used as per CWP safeguarding policy.
- There is inconsistent practice across the Trust in terms of how safeguarding children supervision is recorded.
- Parental factors which could negatively impact on the child were not always considered.
- Children services generally evidence the Child's Lived experience.
- Where parents had been identified as having delusional beliefs, the consultant had good oversight of the case.
- Quality assurance of social care referrals have demonstrated that generally they have all information that is required.
- The outcome of the referral was not always sought in a timely manner.

Looked After Children

- Quality assurance audits undertaken by the children in care service demonstrates high quality assessments are being maintained an evidence of engagement with child/ young person involved.
- Review health assessments are not always received in a timely manner form Social care.

Safeguarding Adults

- The audit demonstrated that there is effective management of adult safeguarding cases that require referral to the Local Authority. Staff have a good understanding of identification of risk and the process that is required to be followed in ensuring that the case is managed appropriately in referring it to the Local Authority.
- The majority of cases referred to the Local Authority were accepted as referrals indicating that the threshold for referral criteria wasunderstood by staff.
- Staff are did not always complete a datix incident form when a referral to Local Authority is made.

- Staff had accessed clinical supervision to support their care of these service user

Domestic Abuse

- Staff do have a clear understanding of their responsibilities when responding to domestic abuse concerns and the MARAC referral process.
- CWP staff have good knowledge that domestic abuse can affect the whole family.
- CARSO risk assessments were not always updated to reflect the identified risk of domestic abuse.
- Effective multi-agency and partnership working was identified in all cases and proportionate risk information was shared in a timely way.

Safeguarding User survey

- The survey was positive with all respondents in the survey stating the service was responsive and advice given by the safeguarding service was helpful.

CWP have also participated in numerous multi-agency case audits. These audits have demonstrated that practitioners are not always utilising evidence based assessment tools, for example, the graded care profile (used for assessment for neglect). These issues will be focus for training and for case auditing during 2016/17.

Internal assurance is supported via several methods including In-patient Safety Matrices and unannounced compliance visits.

CWP submit the Safeguarding Assurance Framework as required for both children and adults for the CCGs in the Cheshire footprint and Wirral. The annual self-assessment audit of safeguarding standards has also been completed and submitted to the CCGs as part of the contractual requirements. A section 11 audit has been completed for Cheshire West and Chester LSCB, which was shared with Wirral LSCB. The resulting action plans from these respective audits have been implemented over the year.

Processes are in place to review reported safeguarding incidents via DATIX reporting system. Head of Safeguarding receives notification of all serious incidents reported within the Trust .

The two serious complaints from Central and East Cheshire action plans have been completed and now closed.

3.15 Progress on key Objectivise for 2015/16

The objectives set out in 2014/15 Annual Safeguarding Report and the evidence of achieving these objectives is summarised in box 3

.**Box 3: Summary of Achievement of Objectives for 2015/16**

Objectives	Evidence of Achievements
Develop opportunities for young people and their families to give feedback on their experience of CWP approach to safeguarding	CWP safeguarding service working with patient participation service and services to develop this. Currently feedback is informal or via comments in case notes. Stronger links for children in care service to obtain feedback is being developed currently.
Launch & implement the new level 3 Safeguarding children-training programme.	The new training programme was launched in September 2015.
Review of the Safeguarding practitioner Link Pilot	SPL programme has now been rolled out to across all localities
Strengthen safeguarding audit programme to evidence learning from reviews and audits.	Safeguarding audit programme including number of case audits focusing on areas of practice as identified in case reviews. Audit programme completed.
Undertake a survey of staff experience of utilising CWP safeguarding service.	Survey was completed and included external agencies.
Service development for children in care	Development of service commenced and processes changed and refined. Still ongoing development work
Implement the guidance "promoting the health of children in care"	Multi-agency policy has been revised by CWP. Practice in CWP in accordance with the new guidelines.
Work with the CCGs to address the increasing pressure on the safeguarding service.	Director of Nursing and Associate Director met with CCGs.
Work in partnership with all safeguarding Adult Boards to respond to introduction of the Care Act 2014	CWP actively participating in the LSABs (see appendix A)
Head of Safeguarding to work with General Managers in ensuring the safeguarding arrangements are robust in response to the	Meeting held with General managers and local authorities. Ongoing work in this year.

integrated agenda.	

4.0 Locality Activity and Performance
CWP is organised into three localities – West, Central & East and Wirral. Each locality has a range of services for children and adults, community services and in-patient provision. Each locality has differing needs and priorities relating to the services it provides and the different service users. All require effective safeguarding leadership and practice and work in partnership with other agencies and Safeguarding Boards.

Each locality section is set out below and describes the key priority areas, challenges and improvements made over the last year. What is clear across all is the increasing complexity of services and increasing need to develop effective relationships across all multi-agency providers.

The CWP Safeguarding Service works across all localities to ensure compliance with regulatory frameworks, the local Safeguarding Boards and Clinical Commissioning Groups pertinent to each locality area. CWP continues to support multiagency partnership working and membership of the safeguarding and domestic abuse boards across all localities are contained in Appendix A.

4.1 Central & East locality Report
Partnership working is detailed in Appendix A.

4.1.1 Safeguarding Children Activity
A variety of services including Adult Mental Health and substance misuse services are engaging with the Early Help agenda. The data shows the 19 practitioners on average per month are involved in TAF activity.

CWP Safeguarding team monitors and reviews all safeguarding referrals made into Social Care. All 52 referrals have been quality assured by the safeguarding children nurse specialists

CWP safeguarding children team received copies of all 187 initial child protection conferences with 68 cases were known to CWP and 71 reports were provided.

CWP have been represented by the Nurse specialist for Safeguarding children at the CSE Operational group meetings and is the CSE champion. CSE and Human Trafficking training delivered by Safe & Sound was hosted by the locality in November 2015. The training was evaluated positively.

The locality have a robust training plan to ensure level 3 training reaches the 80%.

4.1.2 Safeguarding Adult Activity
The number of staff enquiries and contact from Central and East locality has significantly increased this year by 53%.

CWP staff continue to attend Strategy and Professional meetings in relation to Safeguarding Adults and supporting safeguarding investigations.

The nurse specialist for safeguarding adults supports the new CHANNEL panels that have been newly formed in Cheshire East. CWP Safeguarding service participated in the numerous LSAB sub groups that have formed.

4.1.3 Domestic Abuse Activity
CWP participated in the MARAC held in Cheshire East, having attended 24 MARACS in this reporting period. Relevant information was shared in regards to CWP service involvement with a victim, victim's child and perpetrator on 574 high risk domestic abuse cases in comparison to 363 in

2014/15, an increase of 58%. 28 referrals were made by CWP Central and East Services in relation to domestic abuse during 2015/16.

CWP continue to participate in the CEDAP MARAC Steering Group and CEDAP Strategic Domestic Abuse. CWP have contributed in two audits. The first reviewed repeat cases and the second audit considered the information shared and resulting actions in relation to perpetrators.

4.1.4 Key Innovations and Developments
Partnership working in Domestic Abuse
CWP staff from a variety of services including, forensic, criminal justice liaison street triage and substance misuse service attended a working with perpetrators of domestic abuse hosted by Cheshire without Abuse. All staff reported the course was extremely beneficial. There are plans to deliver further courses across the Trust in the forthcoming year.

To ensure effective engagement with Cheshire Without Abuse , stronger links are being forged. CWP substance misuse service will be represented at the CWA Harm Reduction Steering Group. In addition, Mental Health Team and substance misuse team representative at the monthly case discussions to offer specialist advice and strengthen partnership working.

Psychiatric liaison services have worked effectively at Leighton hospital with the Independent domestic Violence advocate in identifying domestic abuse and ensuring appropriate support services are in place for victims before discharge.

Participation and Engagement
CWP contribute to the LSCB training to ensure expertise within CWP is shared to strengthen the multi-agency workforce. Within East locality the Nurse Specialist for Safeguarding Children contributes to the LSCB training that covers mental health issues, drugs and alcohol and domestic violence - 'toxic trio' training.
Cheshire East Pregnancy Liaison Group is hosted by CWP on a monthly basis across two sites. This is a multi-agency forum where agencies come together to ensure appropriate support is offered to this vulnerable client group.

Young advisors continue to champion the voice of the child and have participated in numerous consultations including the substance misuse service , CAMHS and LD CAMHS service.

4.2 West Locality
4.2.1 Partnerships
The West locality covers the footprint of the local authority. Within this locality, sits the Children in Care (Looked After Children) Service and the Paediatric Liaison/ Child Death Nurse Specialist service of CWP. Therefore, the respective reports for both of these specialists' services will be included within this section.

In supporting partnership working the Trust participates in the various multiagency forums and these are detailed in appendix A

4.2.2 Health Visitor Liaison/Child Death Overview panel Nurse Report
Liaison Service
The Nurse specialist for health visitor liaison plays an important essential role in the sharing of appropriate information between Acute Trusts (primarily The Countess of Chester NHS Foundation Trust) and Cheshire and Wirral NHS |Foundation Trust (CWP) provider services by communicating directly with Health Visitors, School nurses and other community health practitioners.

The health visitor liaison service has dealt with daily reports from:

- Countess of Chester Hospital Accident and Emergency department where in the year 1/4/2015 to 31/3/2016 there were **14,181** visits to the department by children up to the age of 16 years.
- Neonatal unit where in the year 1/4/2015 to 31/3/2016 there were **486** admissions
- Paediatric wards where in the year 1/4/2015 to 31/3/2016 there were **448** paediatric liaison referrals
- Other hospitals and departments out of this area. The out of area referrals are not counted as there are too many to analyse accurately.
- Liaison has also been completed from other services within the locality that have identified children with vulnerability factors e.g. Out of Hours, Countess of Chester Hospital safeguarding team.

Monthly figures are displayed in the table 8.

Table 8: Figures for liaison & child death from April 2015-March 2016

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	TOTAL
Child Deaths **(Includes out of area deaths)**	2	0	0	0	0	1	3	0	5	4	1	1	**17**
Neo-natal Deaths (Includes out of area deaths)	1	0	3	0	2	2	1	0	2	3	3	1	**18**
Complex Liaison from COCH (Chester and Ellesmere Port)	28	33	31	38	16	34	25	45	48	42	27	41	**408**
Complex Liaison from COCH (Flintshire)	12	6	11	7	7	9	11	9	9	7	3	4	**95**
Complex Liaison from COCH (Out of area)	4	5	3	6	2	8	5	2	7	7	4	4	**57**
Liaison - Neonatal Unit	28	32	31	43	46	39	54	47	42	38	45	41	**486**
Liaison - Paediatric Wards	26	43	47	52	22	40	48	45	37	27	41	20	**448**
Liaison - Out of Hours	0	0	1	0	2	1	2	2	0	0	2	4	**14**

TOTAL OF ALL LIAISON	**1543**

The nurse specialist attends regional liaison meetings. Effective regional communication and information sharing is valuable and ideas can be shared and developed to increase the effectiveness of the paediatric liaison role, processes and learning.

Training

Quarterly updates and induction training sessions are delivered by the health visitor liaison to community practitioners, physical health, to ensure a good understanding of the paediatric liaison and CDOP roles and to ensure that excellent links are established with practitioners.

Child Death Overview Panel

The nurse specialist is a core member of the Pan Cheshire Child Death Overview Panel (CDOP)

There have been 6 meetings in the Pan Cheshire forum in the year March 2015 to April 2016 with an additional half day meeting to look at forward planning and development of the CDOP process and development. The panel will report on its findings separately with reference to the review of the child deaths across Cheshire, identification of trends and statistics and identification of public health issues.

Within Cheshire and Wirral Partnership NHS Foundation Trust there have been 25 child deaths in the year April 2015 to March 2016 for children registered in the CWP footprint. The nurse specialist has been part of the SUDIC protocol response and has attended rapid response meetings as required. The nurse specialist has then coordinated the health response to the CDOP panel in a

timely way whilst providing supervision to the CWP staff involved and signposting them to staff services if required for additional support. The nurse specialist has also provided health information when requested to out of area CDOPs as requested for children resident out of area but in receipt of CWP services e.g. CAMHS.

The Pan Cheshire CDOP has continued to identify that there have been a number of children die where sleep issues were identified as a modifiable factor. Promoting safe sleep throughout CWP has therefore been a priority with promotion through the Safeguarding Newsletter and promoting Safe sleep training delivered. All staff have been made aware of the issues via e mail and at meetings and additional training has been arranged via the Lullaby Trust to be delivered over the coming weeks to enable CWP practitioners to access local training. The LSCBs have been asked by the CDOP to develop multi-agency safe sleep training in each locality and the nurse specialist has offered to support this. The Lullaby Trust has been identified as an excellent resource and consistency across the footprint will be achieved if all the localities utilise the same training.

The nurse specialist has been a core member of the Pan Cheshire CDOP working group to review and update the Pan Cheshire protocols which are still under review. The nurse specialist ensures that child death information is communicated effectively and securely between multi-agency professionals and that child death reporting is delivered to the Pan Cheshire CDOP in a timely and appropriate way in order for the panel to adequately review deaths. This includes completion of the appropriate department of health child death forms and significant liaison between any involved professionals and where necessary provision of support to the involved professional.

The nurse specialist is able to communicate trends and public health issues to community practitioners to enable consideration for service improvement and training.

The nurse specialist attends quarterly regional CDOP network meetings. Effective regional communication and information sharing is valuable and ideas can be shared and developed to increase the effectiveness of the CDOP process and learning.

4.3.5 Children in Care (Looked After Children)

The children In Care team has seen a number of changes throughout the 2015-2016 with one nurse specialist going on maternity leave and Children In Care Nurse commencing her post within the team in July 2015 to support the children not in education. The team have reviewed processes, and revised multi-agency policies to ensure they are compliant to “Promoting the health of Looked After children” statutory guidance published in 2015. CWP pathways have been streamlined to develop a more efficient and effective service for reporting, recording and information sharing and escalating appropriately issues concerning Looked after Children.

The team continued to provide training regarding promoting the health of children in care every quarter for all Health Visitors, School Nurses and Family Nurses recruited to CWP (as well as to staff returning from extended leave) to ensure quality health assessments are undertaken. The Children in Care Nurses contribute to the bi-monthly Safeguarding Induction training programme for all children service staff.

The Children in Care Nurses have provided clinical supervision for Health Visitors and School Nurses in respect of children on their caseload with Looked after Children status.

The Children in care Team have a responsibility for overseeing the requests for Review Health Assessments ensuring a timely quality assessment is given to this cohort of vulnerable children and young people. The team works closely with Cheshire West and Chester local Authority to ensure the health data of Children in Care is robust.

Quality assurance of review health assessments continues to be undertaken by the Nurse Specialists. Monthly reporting of activity relating to children in care continues to be reported to the respective CCG’s using the Safeguarding Assurance Framework.

The numbers of Children in Care shows an increase, including the number of children aged 16+ years where the Children in care Nurse are the identified health professional.

In recognition of the increase in population of children aged 16+ there is now a Children in care Nurse who is the identified health professional for young people not in school. She undertakes Review Health Assessments and supports young people to take responsibility for their health needs as they become independent. The Nurse Specialists hold a caseload of the most vulnerable cases such as those with a history of sexually harmful behaviour and child sexual exploitation that are placed in Cheshire as well as maintaining contact with the respective Looked After Children Nurses looking after Cheshire West and Chester children who are placed out of area.

The Nurse Specialists work in an integrated way as part of the children in care & care leaver's teams within their localities and work in close collaboration with other agencies including Children in Care Nurses in other areas, physical health & mental health, and allied health professionals in CWP and Social care with Cheshire West and other local authorities.

They regularly participate in the Foster Carer's Induction Training focusing on the health needs of children who are in care, ensuring foster carer's have a greater awareness of the health needs of children in care and how to access health services locally.

The Nurse Specialists have met with representatives of Cheshire West and Chester children and young people who have LAC status via the Children in Care Council to ensure the service that is provided reflects the views and opinions of both the younger and older service users.

4.3.6 Safeguarding Children Activity

A variety of services including Adult Mental Health are engaging with the Early Help agenda. The data shows that 105 practitioners on average per month are involved in TAF activity. A quality assurance process is in place to audit the TAF assessments undertaken by Starting Well services including the FNP service. This audit has been strengthened following the CQC inspection to focus on capturing the voice of the child and wishes and feelings of the child.

CWP Safeguarding team monitors and reviews all safeguarding referrals that have been made into Social Care. All 52 referrals have been quality assured by the safeguarding children nurse specialists.

CWP Safeguarding children team receives copies of all invitations to child protection case. In total CWP have been invited to 178 initial child protection conferences and 245 review child protection conferences. All Clinical staff are expected to submit written conference reports to child protection conferences and 581 conference reports have been submitted by CWP practitioners an increase of 27%. The increase in child protection activity has had a significant impact on Starting Well services including the FNP service.

CWP have been represented by the Nurse specialist for Safeguarding children at the CSE Operational group meetings. CWP supported the multiagency CSE pilot in CWAC as had a Nurse specialist seconded into the team, which ended in March 2016. The Nurse will continue to utilise her experience and knowledge by supporting the LSCB training pool next year by delivering CSE training.

The locality have a robust training plan to ensure level 3 training reaches the 80%.

4.3.7 Safeguarding Adult Activity

The number of Concerns/ Enquires raised for safeguarding adults in west locality has risen from 390 contacts the year before to 443, an increase of 14%. The CWP safeguarding adult team have seen an increase in contact form the community nursing service especially from the specialist nurse in Tissue Viability.

There are no known Adult Case conferences held. However staff continue to attend Strategy and Professional meetings.

4.38 Domestic Abuse

CWP participated in the MARAC held in Cheshire West (including Vale Royal), having attended 36 MARACS in this reporting period. Relevant information was shared in regards to CWP service involvement with a victim, victim's child and perpetrator on 595 high risk domestic abuse cases in comparison to 505 in 2014/15, an increase of 18%.

CWP continue to participate in the CWaC MARAC Steering Group and CWaC Strategic Domestic Abuse.

4.3.9 Service Developments

During 2015/16 transformation of the 5-19 service continued following commencement of new contract commissioned by CWAC in January 2015. A number of new functions within the service commenced including the development of the My well being website to provide information and signposting for children, young people, professionals and parents. This was developed in partnership with children and young people through consultation and workshops to establish the branding, format and content of the site. The site will continue to be developed, led by the engagement and partnership worker within the service and will be the digital platform on which to take forward other elements of the service.

One of these elements is the 'my well-being' online service – mywellbeing.online@cwp.nhs.uk . This provides online supportive therapy for young people between the ages of 10 – 19. Young people can access the service confidentially over email in the form of a 'drop in' which can lead to booked sessions with a therapist who has experience in adolescent mental health, learning disability and psychology. The service has strong links with CAMHS to ensure robust supervision and support. Marketing materials have been developed and distributed to publicise the service which although only operational since January is already demonstrating positive outcomes for the young people who have engaged with the service.

Family Nurse Partnership has continued with acknowledgement at the annual review of the significant contribution the service makes in safeguarding a highly vulnerable group of young mothers and children. The service performs at a high level both in the region and nationally and continues to support the wider Starting Well workforce through integration of training and support pathways.

The supervision model within the service for cases below statutory safeguarding provision has been strengthened through transfer of learning and skills from the Family Nurse Partnership to the wider 0-19 services. This has supported the outcomes for children in ensuring scrutiny and challenge in relation to risks to ensure that they are safeguarded.

The 0-19 service has undertaken a number of audits to assess quality of the service in relation to 'Voice of the Child', Team around the Family, Vulnerable groups and case study audit. The audit of vulnerable groups included accessibility of the service for gypsy roma travellers, electively home educated children and looked after children. The audits demonstrated effective working to support positive outcomes for these groups and also identified actions to be taken forward for improvement.

CWP Starting Well has supported the Early Support Access Team through secondment of a health practitioner into the multi-agency team. This will move on in 2016/17 as this team integrates with CART to become i-ART.

CAMHS service has developed Self-harm pathways/passport for young people to use which was launched on 1 March 2016. These were created in collaboration with young people and CAMHS

practitioners. Young people from the Involvement group have presented the pathway and passport to the Police and Safeguarding Children in Education Team. Young people have assisted the Youth Engagement Officer and Police by giving feedback regarding experience of the custody suites. Further development of the Involvement group is planned within the forthcoming year including launch of the new branding of the group “Listen UP”.

The learning disability service continue to champion service user feedback, having developed ways to capture service user experience of assessment and capturing ‘real time’ feedback.

4.4 WIRRAL LOCALITY
In supporting partnership working the Trust participates in the various multiagency forums within the locality which is detailed in Appendix A

4.4.1 Safeguarding Children Activity
CWP continue to support the Early Help agenda and on average practitioners are involved in 24 TAF cases per quarter.

CWP Safeguarding team monitors and reviews all safeguarding referrals into social Care that they have been notified of being submitted. All 25 referrals have been quality assured by the safeguarding children nurse specialists.

CWP safeguarding department receives copies of all initial case conference invitations. CWP have been invited to 349 initial child protection conferences, 67 cases were known to CWP and practitioners provided reports accordingly.

The Named Nurse represents CWP at the Multiagency Safeguarding CSE operational group in the Wirral.

4.4.2 Safeguarding Adult Activity
The number of concerns/ enquires raised for safeguarding adults in Wirral locality has risen from 181 contacts the year before to 274, an increase of 34%.

CWP Safeguarding has not been notified of any adult safeguarding case conferences being held. CWP staff continue to attend Strategy and Professional meetings.

4.4.3 Domestic abuse and Hate Crime
CWP participated in the MARAC held in Wirral having attended 27 MARAC meetings in this reporting period. Relevant information was shared in regards to CWP service involvement with a victim, victim’s child and perpetrator on 882 high risk domestic abuse cases in decrease from 946 in 2014/15.

CWP have participated in the domestic abuse and MARAC review that was undertaken by Wirral and will be supporting the newly formed MARAC steering Group.

CWP safeguarding have contributed to the Wirral Hate Crime MARAC listings by providing information on cases known to CWP. No referrals have been made by CWP.

4.4.4Service development
Wirral has recently appointed a participation worker who will be working closely with services to ensure that services are engaging with users.

CWP will be supporting the partnership working by supporting the MARAC steering group and continued support to the CHANNEL panels

CWP have supported the new Multi Agency Safeguarding Hub in Wirral by providing training and support to the Nurse specialist employed by the community trust.

5.0 Trust Wide Objectives for 2015/16

The following objectives have been identified as key areas for development for the coming year. They reflect the current and emerging agendas across the locality areas and reflect national and Safeguarding Board priorities as well as internal objectives specific to CWP.:

- Reviewing and implementing the intercollegiate document for adult safeguarding
- Preparing for Goddard inquiry and reviewing the lessons from Bradbury Investigation and implement learning within CWP.
- Safeguarding Strategy for CWP to be refreshed
- Align CWP priorities with the respective safeguarding boards on Wirral, Cheshire West and Chester and Cheshire East.
- Promote the use of evidence assessment tools to support safeguarding practice
- Continue to work with services in ensuring robust safeguarding processes are in response to the integrated agenda.

6.0 Conclusion

CWP has continued to work in partnership across each of the local Safeguarding Boards for both adults and children. The Trust has assessed compliance with regulatory standards in relation to children through completion of the Section 11 Audit self-assessment. The Trust has completed a self- assessment against adult standards based on the 6 principles of adult safeguarding. For Children in Care the report has demonstrated how it has met the statutory guidance on Promoting the Health of Looked After Children 2015.

The report demonstrates how CWP has responded to the key objectives set for 2015/16.

Appendix A: CWP Membership of Safeguarding Boards and Groups
CWP Central and East Locality

Cheshire East LSCB Board	Director of Nursing, Therapies & Patient Partnership
Cheshire East LSAB Board	Associate Director of Nursing & Therapies (Physical Health)
Cheshire East Business Managers Group for LSAB	Associate Director of Nursing & Therapies (Physical Health
Trafford LSAB Board	Clinical Service Manager
Cheshire East Domestic Abuse Board	Head of Safeguarding
Learning and Development Cheshire East LSCB Sub Group	Head of Safeguarding (chair and attended until end of Dec 2015)
Audit and Case Cheshire East LSCB Sub Group	Named Nurse for Safeguarding Children/Children in Care
CSE/ Missing From Home Cheshire East Sub Group	Named Nurse for Safeguarding Children /Children in Care
CSE Champions Group Cheshire East LSCB	Nurse Specialist for Safeguarding Children
Safeguarding Children Operational Mangers Group Cheshire East	Nurse Specialist for Safeguarding Children
Quality Assurance Cheshire East LSAB Sub group	Associate Director of Nursing & Therapies (Physical Health) – is the Chair of this sub group
Case Review Cheshire East LSAB Sub Group	Head of Safeguarding
MCA and DOLs Cheshire East LSAB Sub Group	Nurse Specialist for Safeguarding Adults
Learning and Development Cheshire East LSAB Sub group	Head of Safeguarding
Policy and Procedure Cheshire East LSAB Sub group	Head of Safeguarding
Community Prevention & Awareness LSAB sub-group	Nurse Specialist for Safeguarding Adults
CEDAP MARAC Steering Group	Nurse Specialist for Safeguarding Adults

CWP West Locality

CWAC LSCB Board	Director of Nursing, Therapies & Patient Partnership

CWAC LSAB Board	Associate Director of Nursing & Therapies (Physical Health)
Domestic Abuse Partnership Strategic Management Board	Head of Safeguarding
Learning and Development CWAC LSCB and LSAB Joint Sub Group	Head of Safeguarding
Safeguarding Children Operational Mangers Group CWAC	Named Nurse for Safeguarding Children/ Children in Care & Named Doctor for Safeguarding Children
Quality Assurance CWAC LSCB Sub group	Named Nurse for Safeguarding Children /Children in Care
Policy, Procedure and Practice CWAC LSCB Sub group	Named Nurse for Safeguarding Children / Children in Care (Deputy chair until February 2016)
Case Review CWAC LSAB Sub Group	Head of Safeguarding
MCA and DOLs CWAC LSAB Sub Group	Nurse Specialist for Safeguarding Adults
CWAC MARAC Steering Group	Nurse specialist for Safeguarding Adults
Children in Care Group (Children Trust)	Named Nurse for Safeguarding Children / Children in Care and CAMHS Team Manager
Child Death Overview Panel (Pan Cheshire)	Nurse Specialist for CDOP/ Liaison

CWP Wirral Locality

Wirral LSCB Board	Director of Nursing, Therapies & Patient Partnership
Wirral SAPB Board	Associate Director of Nursing & Therapies (Physical Health)
Performance Wirral LSCB Sub Group	Named Nurse for Safeguarding Children/ Children in Care
Policy, Procedure and Practice Wirral LSCB Sub Group	Named Nurse for Safeguarding Children/ Children in Care
Staying Safe Group (now dissolved)	Named Doctor for Safeguarding Children
Learning and Development Wirral LSCB and SAPB Joint subgroup	Head of Safeguarding
SAPB Performance and Quality Sub Group	Head of Safeguarding
SAPB Case Review Sub Group	Head of Safeguarding

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Medicines Management Annual Report 2015-16
Agenda ref. no:	16/17/41
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	29/07/2015
Presented by:	Dr Anushta Sivananthan, Medical Director

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	No
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
Click here to enter text.	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
Click here to enter text.	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

It is a statutory obligation to give an annual report to the Trust on the activities of the Medicines Management Group (MMG). This report meets the standards set by the Care Quality Commission (CQC) for the management of medicines which are monitored under the five domains of: Are services safe, effective, caring, responsive to people's needs and well led?

This report covers the year April 2015 – March 2016 inclusive.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

This report details the activity and progress that have been made by the Medicines Management Group (MMG) against the group's annual business cycle.

Assessment – *analysis and considerations of options and risks*

The report outlines the progress and achievements made during the financial year 2015-16.

The following areas are discussed in the report:

Adherence to the various medicine formularies, Incident reporting on medication errors, NICE guidelines and technology appraisals, medicines governance, training and education, clinical audits on medicines, non-medical prescribing and pharmacy services.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors are asked to discuss and approve the annual report.

Who/ which group has approved this report for receipt at the above meeting?	Medicines Management Group 16/06/16
Contributing authors:	Various from MMG membership

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
2	Dr. A. Sivananthan	04/07/16

Appendices provided for reference and to give supporting/ contextual information:
Provide only necessary detail, do not embed appendices, provide as separate reports

Appendix no.	Appendix title
1	Medicines Management Annual report 2015-16

16_17_41 Appendix 1

Medicines Management Annual Report 2015-16

1. PURPOSE OF THE REPORT

It is a statutory obligation to give an annual report to the Trust on the activities of the Medicines Management Group (MMG). This report meets the standards set by the Care Quality Commission (CQC) for the management of medicines which are monitored under the safe domain.

This report covers the year April 2015 – March 2016 inclusive.

The Board of Directors are asked to discuss and approve the annual report.

2. SUMMARY

This report details the activity and progress that have been made by the Medicines Management Group (MMG) against the group's annual business cycle. In particular it focuses on the following areas of responsibility of the group:

a. Formulary adherence and new medicines
b. NICE Technology appraisals and guidance
c. Response to patient safety alerts and other external standards
d. Medication incident reporting
e. Policies/guidelines approved in medicines management
f. Duties of the Accountable Officer for controlled drugs
g. Non-medical prescribing
h. Education and training in medicines management
i. Clinical audit and research
j. Medicines management strategy
k. Pharmacy service
l. Infection, prevention and control

The Medicines Management Group (MMG) is multidisciplinary with members from across the organisation including service user representation and representatives from each of the Clinical Commissioning Groups that commission our services as well commissioning support unit medicines management team representatives.

3. DISCUSSION – Developments and progress against the business cycle

The Group has met eight times over the 12 months of 2015 -16. Attendance at meetings and all declarations of interest from members are documented.

The key developments over the last 12 months are detailed in the following sub-sections.

3.1 Formularies

The CWP Mental Health medicines formulary was launched in March 2013. In line with the recommendation from NICE the formulary is accessible from the Trust public facing website: http://www.cwp.nhs.uk/ The formulary is a reference guide that highlights the formulary decisions approved by the CWP Medicines Management Group in conjunction with Primary Care. Medicine selection is based on evidence of efficacy and adverse effect profile, and prudent considerations around acquisition cost.

The formulary was last updated in July 2014. The pharmacy team are currently in the process of reviewing the formulary again to ensure that all recommendations are in line with current national guidance. This review has been delayed due to the capacity issue this year.

Physical health medicines are prescribed within the Trust in line with our local Acute Trusts and Clinical Commissioning Group formularies – East and South Cheshire, Western Cheshire and Wirral Commissioning Groups.

CWP have adopted the Western Cheshire primary care antimicrobial guidelines as the template for empirical prescribing within the Trust, this adoption was ratified in April 2015.

3.2 Formulary adherence and new medicines

This paper highlights new medicines coming on the market, those that have a change or extension of indications, medications with patents that have expired or are due to expire within the year.

Table 1 below illustrates decisions that have been made regarding applications for medicines:

Table 1

Medicine	Indication	Decision of MMG
Lurasidone (Latuda®)	Schizophrenia	Non-formulary option. Requested via the named patient request route for patients who have failed a trial on Aripiprazole which was limited in effect and who continue to have metabolic adverse effects from antipsychotics or through familial history.
Lisdexamphetamine (Elvanse Adult®)	Adult Attention Deficit Hyperactivity Disorder (ADHD)	Alternative where stimulants are not contraindicated for patients who require symptom control for greater than 12 hours. For those unable to swallow capsules or tablets. As per the treatment algorithm for the service.
Switch to branded generics of Methylphenidate Concerta® XL called Xenidate® XL and Matoride® XL	Attention Deficit Hyperactivity Disorder (ADHD)	Switch established patients on Concerta® XL to Xenidate® XL. Initiate new patients on Xenidate® XL in place of Concerta® XL
Vortioxetine (Brintellix®)	Treatment for adults having a first or recurrent major depressive episode, if the current episode has not responded to 2 antidepressants.	Non-formulary option. 3rd line option requested via the named patient request route in order to monitor efficacy as limited evidence base. This was subject to a NICE TA in Nov'15.

In addition to monitoring inpatient adherence to the formulary, the pharmacy team review reports on outpatient prescribing from FP10 prescriptions. The information gleaned from these reports is shared with the locality directors and Clinical Directors to monitor adherence and address non-adherence with the Trust formulary through the locality quality and governance meetings.

3.3 Named patient/non-formulary requests

There have been several requests during the year for non-formulary medicines. These are divided into general non-formulary requests and antipsychotic non-formulary requests.

In all approved cases the MMG request feedback from the consultant prescriber on progress with the treatment every three months so that MMG can be reassured that the treatment continues to be beneficial to patient care.

3.4 Product Updates

The Medicines Management Group receives updates at each meeting. For year 15/16 The Group received in total, 55 product updates throughout the course of the meetings. The report details changes in product formulations, updates of undesirable effects, interaction with other medicinal products, special warnings and precautions for use, contraindications and supply problems for products relevant to prescribing within CWP.

In last year's report it was stated that these updates would be distributed trust wide, the updates are loaded to a section of the pharmacy homepage at the beginning of each month. Communication bulletins and alerts are also circulated to clinical staff.

The product updates continue to be reviewed each day via email updates from NICE. Any immediate problems identified are actioned accordingly and product updates are added to the month's list ready for distribution.

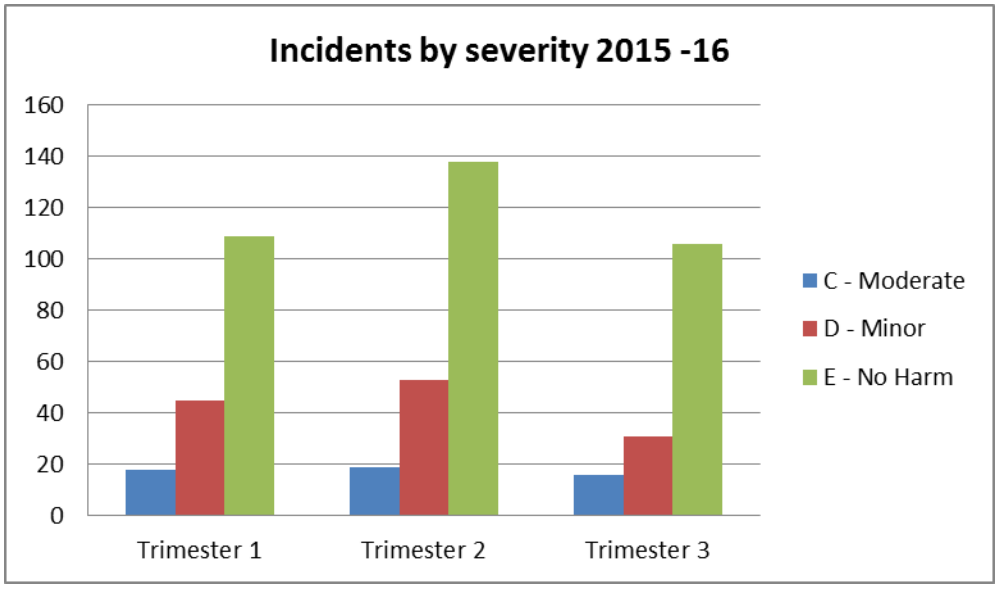
3.5 NICE Clinical Guidelines/Technology Appraisals

The Group looks at the medicine component of any technology appraisals (TAs) and clinical guidelines (CG) applicable to our service users/carers. In line with the work plan all the medicine components of NICE Clinical Guidelines (CG) and Appraisals (TA) are rated using the red/amber/green system and are reviewed at each meeting. There are currently 18 TAs applicable (end of March 2016) to CWP; all of these are rated as 'Green'. There has been one published National Guideline (NG) over the last 12 months which have been reviewed for medicines components this is NG10 Violence and Aggression short term management. Current work includes the development of outcomes and pathways of care for our patient records integrating NICE standards.

3.6 Incident Reporting of Medication Errors

Graph 1 below illustrates the number of reported medicines-related incidents over the last 12 months broken down by severity. The majority of the incidents fall into category E. It can be seen that there were no category A or B medication incidents during this time period.

Graph 1: Incidents by severity



3.6.1 Trends in reported medicine related incidents

Graph 2 below details the number of incidents per sub-category over the 12 month period. It can be seen that there are two sub-categories with higher than average frequency:

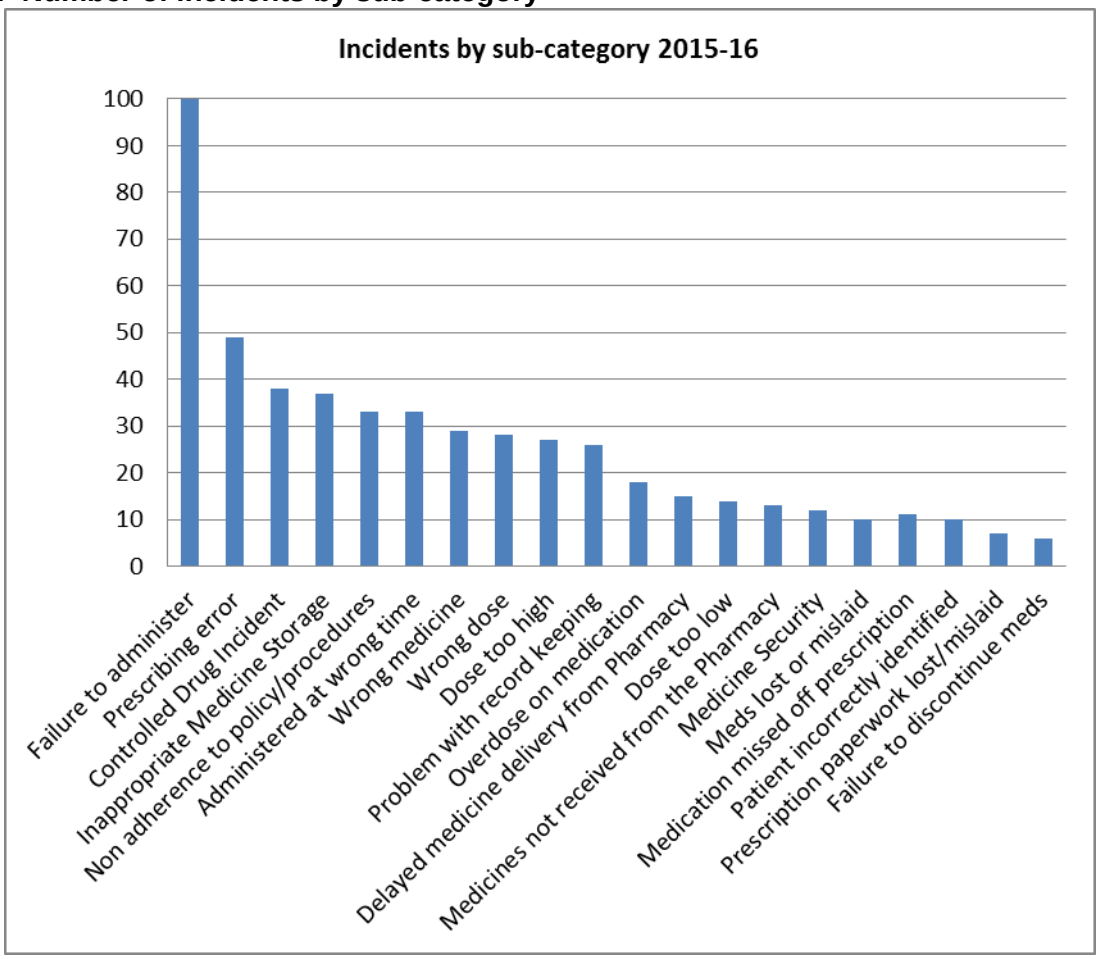
- Failure to administer (100)
- Prescribing error (49)

Three other sub-categories have similar incidences:

- Controlled drug incidents (38)
- Non-adherence to policy / procedures (33)
- Inappropriate medicine storage (37)

There are actions plans in place to reduce these incidents.

Graph 2: Number of incidents by sub-category



3.7 Policies/guidelines/patient group directions/leaflets approved for use within the Trust

3.7.1 The following policies/guidelines have been approved and implemented Trustwide

- DA8– Policy for inpatient and out of hours management of drug misusers - April 2015
- MP4 - Lithium Policy - July 15
- MP3 – Guidance on the recommended psychotropic agents for use in pregnancy and lactation – June 2015

3.7.2 Patient Group Directions

An increasing number of the Trust PGDs are written by Public Health England in conjunction with NHS England and signed at both a local and regional level. Where regional patient group directions are not available, or not appropriate for adoption a new PGD has been written and then ratified at the Medicines Management Group.

During the CQC inspection, it became apparent that some members of staff were unfamiliar with their responsibilities under the PGD. As a result of this, all PGDs were digitised and placed in an easily identifiable folder on the pharmacy home page of the intranet. The pharmacy technician has contacted all team leaders who work under PGDs to advise them of such and maintains the page whenever a PGD changes.

3.7.3 Patient Information Leaflets

In June 2015 the "best use of medicines in pregnancy" (BUMPs) leaflets were approved along with providing links to these from the Trust internet/intranet http://medicinesinpregnancy.org/Medicine--pregnancy/

3.8 Clinical governance and external standards

3.8.1 CQC Inspection in June 2015

The Trust CQC inspection in June 2015 identified that we had an effective medicines governance and incident reporting structure in place. The inspection identified some shortcomings in terms of appropriate medical representation at the medicines management group which may impact on the group's analytical and decision making processes. There were some concerns about the use of patient group directions in some of the physical health teams, which have now been addressed. Some minor issues were identified falling out of the medicines management annual audit in terms of all teams and wards participating in the audit as a must do.

3.8.2 Overview medicines governance

The Trust continues to monitor compliance with policies in relation to medicines management via the annual audit programme and via review of incidents, as outlined in the relevant sections of this annual report.

3.8.3 Internal assurance

Safe, effective and responsive use of medicines is assessed as part of the trust's programme of compliance visits to the wards and community teams.

3.8.4 NHS England Patient Safety Alerts

We have responded to two patient safety alerts this year namely:

- *Stage 2: addressing antimicrobial resistance through implementation of an antimicrobial stewardship programme*
- *Stage 2 resources: Support to minimise the risk of distress and death from inappropriate doses of naloxone*

For both alerts an action plan was devised around outstanding actions required by CWP. The first alert has now been closed and the second one is still in progress due to be closed off imminently once a decision has been reached about the availability of Naloxone (used for opioid reversal) across the Trust.

3.9 Accountable Officer for Controlled Drugs

The Accountable officer for controlled drugs is the chief pharmacist and as such is a member of the Cheshire, Wirral and Warrington local intelligence network of Accountable Officers. The Accountable officer provides two six monthly reports to the MMG on the management of controlled drugs within CWP, the reports for 2015-16 have been approved by MMG. The majority of concerns raised in the reports are minor and relate to standards of practice which are addressed at the time of reporting.

3.10 Pharmacy Services

There have been key personnel changes within the pharmacy team during the year which resulted in four senior pharmacist vacancies during the summer of 2015, since then we have had two further vacancies between February and April 2016, this totalled 5.24 full time equivalent pharmacist posts. This afforded us the opportunity to review the staffing structure within the team and then appoint to the vacancies in the new team structure. At present we have 2.8 pharmacist vacancies of which 1.2 vacancies will be filled in September 2016. To date we are struggling to fill the remaining 1.6 vacancies which has meant appointing two locum pharmacists in the interim.

The team have continued to work diligently with our preferred supplier of medicines, Lloydspharmacy, over the last 12 months. The operation of the service from the old training room in Bowmere commenced in May 2015, this was after completion of the refurbishment of the room into a functional pharmacy dispensary. The contract with Lloydspharmacy is tightly monitored monthly by the senior pharmacy technician and chief pharmacist via the contract monitoring meetings at which the key performance indicators of the contract are reviewed and discussed. We have an escalation plan in place to address any breaches through the superintendent's office.

3.11 Staff Training in Medicines Management/External Training Delivered

The pharmacy team in the East have delivered several sessions at Crewe and Macclesfield Recovery College around the topics of psychotropic medicines and their effects on physical health as well as sessions on "Understanding your medicines". Some of these sessions were part of a new healthy living course offered by the Recovery College. The pharmacist in West has supported the Recovery College in their series of sessions on understanding your medicines and healthier lifestyles. This has included a peer support person facilitating the final session in the series bringing together the actions for medicines management and healthy lifestyle. All of these sessions were well received with very good feedback.

Each year the pharmacy team supports six pre-registration pharmacists, from neighbouring acute trusts, for week long placements. Instilling an interest in mental health, an awareness of common mental illnesses and experience in communication with people with mental illness should improve the contribution these pharmacists make to people's care in whichever care setting they work. Excellent feedback was received by the teams in all localities involved. The team also gave lectures about mental health illnesses and their treatments at the pre-registration study day.

The pharmacy team continue to provide psychopharmacology education to junior doctors on the MRCPsych course organised by Liverpool University. This covered antipsychotics, antidepressants and mood stabilisers.

In 2016 Liverpool John Moore's University invited the Pharmacy Team back for the sixth time to facilitate the Psychiatry and Neurology Study Weekend for their Postgraduate Diploma in Clinical Pharmacy. Sessions were delivered by clinical pharmacists and guest speakers. The final session of the study weekend was delivered by a CWP service user and carer who were able to share their perspective and experiences of mental health with the students. This session once again proved to be very interactive, popular and informative for the students.

As in previous years the pharmacy team has provided medicines management training sessions at the trust-wide junior doctors' induction and the team in the East also provided regular training at the local doctors' teaching sessions.

Input and support to the Musculoskeletal Service in the West consists of delivering regular talks to a group of service users regarding medicines management and the usage of analgesia (pain killers). These sessions provide the opportunity for one to one time and service users find this service very helpful and with positive feedback.

3.12 Non-Medical Prescribing

Non-Medical Prescribing (NMP) is the practice whereby nurses, pharmacists, optometrists, physiotherapists, podiatrists, radiographers (supplementary) and community nurse practitioners are legally permitted to prescribe medication .

The trust employs a total of 170 non-medical prescribers (NMPs) who work across both physical and mental health services.

The table below illustrates the breakdown of our NMPs within the organisation.

Service	Number of Prescribers
Adult and Older People Mental Health	17
CAMHS	1
Memory Clinic	2
Drug and Alcohol Services	3
Independent prescribers in physical health	37
Community practitioner nurse prescribers physical health (mainly health visitors)	86

In February 2016 seventy nine NMP's attended a CWP NMP conference which included presentations from the Yellow Card Scheme and Hill Dickenson solicitors on legal issues in prescribing. Time was also given to sharing case studies and refreshing clinical assessment skills.

3.13 Research and Clinical Audit

3.13.1 Research

An update is provided at each MMG meeting of research recently approved and all research ongoing in the Trust both Portfolio Research and Non-portfolio research. Clinical Trials of an Investigational Medicinal Product (CTIMP) are notified to the MMG as soon as possible. Currently there are two CTIMP trials. The ATLAS trial determines whether amisulpride (an antipsychotic) is superior to placebo in the treatment of very late-onset schizophrenia-like psychosis. There is also Benemin which used minocycline in patients with psychosis to see if it improves negative symptoms. A third study we are involved with is a multicentre, double-blind, randomized, placebo-controlled study of the safety, tolerability and immunogenicity of ACI-35 in patients with mild to moderate Alzheimer's disease. This is a sub cutaneous injection dosing study aimed at modifying Tau pathology in the brain. Tau protein attributes to the development and progression of dementia in brain cells.

3.13.2 Audits on medicines

3.13.2.1 Medicines management annual audit

The Audit for 2015 is due to take place in September.

3.13.2.2 Antibiotic Audits

The antibiotic audits are conducted quarterly in physical health services and prospectively for all antibiotics prescribed in inpatient mental health services.

3.13.2.3 Controlled Drugs Audits

A quarterly controlled drugs audit is conducted on compliance with the controlled drug regulations in all inpatient units and the GP out of hours service. In addition quarterly monitoring of controlled drugs in the drug and alcohol service is monitored via regular meetings with the clinical director to review medicine usage within the service. Results of such audits and in particular non-compliances with controlled drug standards are reported through the Accountable Officer's network. The NHS Protect ward self-assessment which was conducted for the first time in 2015 also looked at storage of controlled drugs and highlighted the issue of separate storage of patients own controlled drugs. This action was addressed within our inpatient units.

3.13.2.4 High dose antipsychotic therapy audit

An audit of MP18 High dose antipsychotic therapy (HDAT) guideline was conducted across the East community mental health teams in early 2015 to test out the feasibility of such an audit in this patient group, as previously it was conducted across inpatient units. The audit identified limitations in that it was not as easy to identify all community patients who were subject to high dose antipsychotic prescribing as prescribing was shared across CWP and the GP. The conclusion was that further work was required in agreeing an appropriate data collection tool to capture the relevant information as well as being able to monitor the physical health aspects to this across community teams.

3.13.2.7 Prescribing Observatory for Mental Health (POMH UK)

CWP joined the Prescribing Observatory for Mental Health (POMH UK)[1] in April 2010. This was to enable the Trust to participate in national benchmarking of prescribing in mental health. Reports for 'Prescribing ADHD in children, adolescents and adults' and 'Prescribing of sodium valproate for bipolar disorder' were received for this year with the data collection period taking place in May and September 2015, respectively. CWP has promoted good practice and supported improvement where necessary following the results of the audits. This is in line with the Trust's Zero Harm Strategy.

3.13.2.8 Medicines reconciliation audit and Patients Own Drugs (POD) Audit

The POD audit will be conducted in June 2016 and will incorporate new data that identifies those admissions that have been transferred from an acute trust. It will also ascertain if they have any discharge medicines transferred with them.

The new data collection for the POD audit will include information on any service user admitted with a blister pack. The aim of this exercise will be to identify the cost of wasted medicines as blister packs are not routinely reused on admission as per trust policy.

We have also reviewed the medicines reconciliation policy to include new NICE guidance (NG5)[2] and are working with ICT services to update our electronic medicines reconciliation form in line with this guidance.

The data for the medicines reconciliation audit is being collected presently and the final report will be presented to June MMG.

3.14 Links with infection, prevention and control (IPC) sub-committee

A clinical pharmacy technician attends the infection, prevention and control sub-committee (IPCSC) and works alongside the IPC team to review antibiotic usage and audit results, contributing to the Trust influenza immunisation programme and promotion of the antibiotic formulary. The pharmacy team have also developed a dental formulary which we hope to share trust wide once approved.

In line with the Health and Social Care Act 2008 Code of Practice, and our contractual obligations, four point prevalence audits took place over the last year to measure our adherence to the antibiotic formulary that is in place across the Trust for inpatient services. In addition antibiotic usage across CWP West Physical Health was audited each quarter using ePACT prescribing reports all CWP prescribers now have a forum where they can discuss their prescribing. For the year 2015/16 all physical health prescribing fell within the national targets. Reports of all antibiotic audit findings are discussed at both MMG and IPCSC and the recommendations from the audits are again monitored by both groups.

3.14.1 Inpatient services antibiotic formulary adherence 2015-16

The team has collected information together for the 12 month period, below is a summary of the findings.

There were 500 prescriptions for antimicrobials on the inpatient units across the trust last year. 92% of the treatment prescribed complied with the trust formulary. 29% of all prescriptions involved some form of tissue damage whether this is through self-harming behaviours or pressure ulcers. The pharmacy team and IPC team continue to work together to further improve CWP's antimicrobial prescribing.

3.14.2 West Cheshire Physical Health Services Antibiotic Prescribing 2015-16

Prescribers follow current NHS West Cheshire antibiotic guidelines v1 which are currently under annual review. The prescribers are:

- Out of Hours service – A mix of medical (GP) and nurse independent prescribers
- Community Matrons – nurse independent prescribers based in the community

CWP West Physical Health antibiotic benchmarking is currently measured against one local and national measures:

- Local - compliance with NHS West Cheshire antibiotic formulary.
- National comparators:
    - Prescribing comparator "Cephalosporins and quinolones % items" This is defined as "the number of prescription items for cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial items". Cephalosporins and quinolones have a higher propensity to cause *Clostridium difficile* associated disease. Prescribing of these antimicrobials cannot be totally eliminated due to sensitivities and resistance, so the target is to keep usage as low as possible and in line with West Cheshire CCG and national levels.

Data below compares out of hours prescribing against the prescribing for the previous financial year,

Out of Hours - all prescribers	**CWP West Average 14/15**	**Q1 15/16**	**Q2 15/16**	**Q3 15/16**	**Average YTD 15/16**
Formulary antibiotic items	2294	2372	2048	2599	2340
All antibacterial items	2330	2406	2071	2636	2371
% Formulary antibiotic items	**99%**	**98%**	**99%**	**99%**	**99%**
Ceph & Quin items only	121	134	100	89	108
All antibiotic items	2330	2406	2071	2636	2371
% Cephalosporin + quinolone	**4%**	**5%**	**5%**	**3%**	**4%**
Out of hours - GP only					
Formulary antibiotic items	2184	2213	1969	2482	2221
All antibacterial items	2219	2248	1992	2519	2253
% Formulary antibiotic items	**98%**	**98%**	**99%**	**99%**	**99%**
Ceph & Quin items only	117	128	100	86	105
All antibiotic items	2219	2248	1992	2519	2253
% Cephalosporin + quinolone	**6%**	**6%**	**5%**	**3%**	**5%**
Out of hours - NMP	**CWP West Average 14/15**	**Q1 15/16**	**Q2 15/16**	**Q3 15/16**	**Average YTD 15/16**
Formulary antibiotic items	111	42	79	117	79
All antibacterial items	111	42	79	117	79
% Formulary antibiotic items	**99%**	**100%**	**100%**	**100%**	**100%**
Ceph & Quin items only	4	0	0	3	1
All antibiotic items	111	42	79	117	79

% Cephalosporin + quinolone	**3%**	**0%**	**0%**	**3%**	**1%**

Overall, prescribing values have been maintained at a high level and consistent with the previous year's results. The percentage of cephalosporin and quinolone prescribing as a total of all antibiotic prescribing, 4% is also in line with local and national average results.

Community matron prescribing of antibiotics is low but has reached 100% formulary adherence and sustained this level for the three quarters reported.

3.15 Medicines Management Strategy 2015-19

This sets out the vision of objectives to meet over the next 5 years for medicines across CWP. We consulted on the strategy[3] with the clinical services at a Clinical Engagement and Leadership Forum back in June 2014 and with the pharmacy team. It was subsequently approved at MMG in April 2015 and then Operational Board in May 2015.

The medicines management strategy aims to complement and support the clinical strategies in their milestones of delivery.

3.16 Electronic prescribing and medicines administration (ePMA)

Work recommenced on the preparation for ePMA in July 2015 with the appointment of the project manager. A project board and project team was established and a successful launch event was had on the "vision for ePMA for CWP" in January 2016. The ePMA team and Board have worked hard to develop a specification of need for CWP which was signed off by the project board in May.

4. CONCLUSION

This report has detailed the work of the medicines management group and the pharmacy team led by the chief pharmacist and associate director of medicines management over 2015-16. The medicines management group will work to the new business cycle set for 2016-17 and report regularly through the integrated governance structures of the Trust.

5. RECOMMENDATIONS

The board of directors is asked to discuss and approve the medicines management annual report.

6. REFERENCES

1. *POMH-UK website*
   http://www.rcpsych.ac.uk/crtu/centreforqualityimprovement/prescribingobservatory.aspx

2. *Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE guidelines, NG5 (March 2015)*

3. *Medicines management strategy 2015-19*
   http://nww.cwp.nhs.uk/TeamCentre/Pharmacy/PublishedDocuments/Medicines%20management%20strategy%20-%20Final.pdf

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Annual Medical Appraisal report
Agenda ref. no:	16/17/42
Report to (meeting):	Executive Board
Action required:	Discussion and Approval
Date of meeting:	27/07/2016
Presented by:	Dr Faouzi Alam, medical Director

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	No
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	No
Capability and culture	Yes
Process and structures	Yes
Measurement	No
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
35T	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

Each year designated bodies are required to complete an Annual Organisational Audit (AOA) on appraisal and revalidation in order to gain an understanding of the progress made during the last year, and assure Responsible Officers and Executive Boards as well as NHS England that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent.

Following the AOA, designated bodies are encouraged to produce a status report and review their organisation's developmental needs in this area.

The board is asked to receive this status report and complete a statement of compliance (appendix 2) , submitting it to NHS England by 30/9/2016.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The systems for appraisal and revalidation and responding to concerns have all gone reasonably smoothly over the last year. The creation of the Medical Workforce Manager post and Medical Appraisal Administrator post have been successful and the two incumbents have worked collaboratively and effectively with Medical Education and HR ensuring a joined up approach.

In 2016 the Mersey Internal Audit Agency carried out an audit into CWP's processes in appraisal and revalidation and was complimentary about their findings.

Assessment – *analysis and considerations of options and risks*

1. Recommendations on doctors' fitness to practice
30 recommendations for revalidation were made to the GMC between 1/4/15 and 31/3/2016: none were deferred.

2. Arrangements for medical appraisal
We now have 32 appraisers which is more than adequate. Systems for assuring the quality of appraisals have been tightened up along with regular opportunities for appraisers to share good practice.

3. Arrangements for responding to concerns
There have been 2 formal investigations into doctors' practice over the last year with one written warning and one doctor being moved to another post with an action plan to address the concerns.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors is recommended to **approve** the report and the Chief Executive is asked to sign the attached statement of compliance required for NHS England.

Who/ which group has approved this report for receipt at the above meeting?	35T
Contributing authors:	Geraldine Swift, Faouzi Alam, Sarah Carroll

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
35T	People and Organisational Development subcommittee	July 2016

Appendices provided for reference and to give supporting/ contextual information:
Provide only necessary detail, do not embed appendices, provide as separate reports

Appendix no.	Appendix title
1	Annual Report 2015/16
2	Statement of Compliance

16_17_42 Appendix 1

Revalidation, Appraisal, Concerns – annual report 2015/2016

This appendix contains a more detailed analysis on the recommendations made regarding:

1. CWP's doctors' fitness to practice;
2. Arrangements for and outcomes of medical appraisal;
3. Arrangements for and outcomes of responding to concerns involving doctors.

1. Recommendations on Fitness to Practice

CWP has 95 doctors for whom Dr Alam as RO is responsible: 83 consultants and 12 SAS doctors. This excludes medical trainees from Deaneries and GPs doing sessions in CWP where the bulk of their work is within primary care. This is a slight reduction from last year (98 doctors with a prescribed connection).

30 recommendations for revalidation were made to the GMC between 1/4/2015 and 31/3/2016. One doctor who had been deferred from November 2014 because of lack of colleague feedback was able to complete this and was recommended for revalidation in May 2015. All recommendations were completed on time and there were no notifications for non-engagement.

Only 2 more doctors from CWP's original cohort are due recommendations in 2016 and 2017; after which all will have been revalidated once.

2. Appraisal

a. Activity levels of appraisal:

In 2014/15, NHS England brought in new categories for counting appraisals in recognition of the fact that minor issues regarding timing are not necessarily of concern –e.g. "1b" appraisals include situations where the appraisal is completed but there is a delay of more than 28 days before the doctor and appraiser sign it off.

In 2015/16, 85 doctors (73 consultants and all 12 SAS doctors) were appraised and outputs signed off. Two RO letters were issued to doctors who had not set appraisal dates within the timeframe despite prompts and they both subsequently engaged with the appraisal process. 10 consultants had an incomplete or missed appraisal – all of these had been approved by the RO for reasons that included maternity leave and longterm sickness. There were no instances of unapproved incomplete or missed appraisal.

Compared to last year, there were more doctors who were categorised as 1b (ie full appraisal but delays in signing it off) or 2 (approved incomplete appraisals):

	2014/15	2015/6
1a Number of completed appraisals where all went according to plan	76	33
1b Number of completed appraisals where there were minor problems in timing	17	40
Number of approved incomplete appraisals	5	10
Number of unapproved incomplete appraisals	0	0

This way of categorising appraisals was introduced last year. It is the impression of the Medical Workforce group that the change in the numbers represents a greater rigour in categorising the timing requirements around appraisal rather than a deterioration in performance but this will need to be monitored.

b. Appraisers

A training session for doctors being appraised was held over the past 12 months.

CWP now has 32 appraisers in total which is more than we strictly need: however doctors who attend training as an appraiser tend to become more enthused about the appraisal process and this impacts on their own appraisal. Thus it is anticipated that offering regular appraiser and appraisee training will continue in future years.

The appraisal support group facilitated by the AMD and Medical Workforce Manager (MWM) has continued to meet twice yearly and has been well attended. Terms of reference for the group have been drawn up: as recommended by NHS England the purpose is to provide peer support to appraisers, share good practice and inform appraisers of changes in appraisal and revalidation taken centrally.

c. Quality Assurance of Appraisal

Assurance around the quality of information gathered for appraisal:

- Review of all appraisal folders to provide assurance that the appraisal inputs: ie the pre-appraisal declarations and supporting information provided is available and appropriate -– provided by the MWM.
- Since last year and in line with plans in last year's report, we have introduced new checks where data on prescribing outliers is routinely sought from pharmacy; and we also now seek information from MHA office on any problems in the use of MHA. This information is requested by the Medical Appraisal Administrator (MAA) and uploaded to the appraisal portfolio.
- The recommendations from NHS England that each doctor is appraised for a maximum of 3 years by a single appraiser has meant that more and more doctors have an appraiser who is not their line manager. This offers a fresh pair of eyes and a different approach for the appraisee. It can mean that if there were challenges or difficulties during the year that the

appraisee does not bring up at appraisal, then the appraiser might not know of their existence. Last year this was picked up by the MWM and AMD and appraisers and appraises were asked to have a further conversation before the appraisal was signed off. We therefore introduced a system where a CD who is not appraising one of their own doctors is now automatically notified of the appraisal date. The CD is asked to highlight any instances of outstanding practice or concerns that have occurred during the year to the appraiser and appraisee.

This has bedded down over the last year as people have grown used to it. Anecdotally we are aware that it is the doctors who are struggling most where the system is least likely to work effectively – perhaps because the CD finds it difficult to raise concerns in a constructive manner when the appraise is often still under investigation or the disciplinary issue has not concluded. In benchmarking against peers across the North West, it is clear that this triangulation of appraisal with managing medical concerns is an area of difficulty for all trusts and our processes are seen as more developed than most.

Assurances around the quality of the appraisal discussion and the appraisal summary:

- Rolling review of appraisal summaries (one third each year on a 3 year cycle) to provide assurance that the appraisal outputs: ie PDP, summary and sign offs are complete and to an appropriate standard using a quality assurance tool– provided by the AMD.
- Review of appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs – appraiser, AMD, MWM.
- Feedback from appraisee to the appraiser and to the MWM on their experience of the appraisal process

Assurances around the quality of data submitted as the Annual Organisational Audit to NHS England:

- Audit of timelines of process of appraisal – maintained by the MWM.

At CWP's request, an audit was carried out by the Mersey Internal Audit Agency into our appraisal and revalidation system. The resulting report was positive – a review of portfolios found that all output forms were found to be fully completed with a good level of detail. 2 low and 1 medium risks were identified but the MIAA said that their impact would be minimal or that they would be unlikely to occur. The risks identified included the absence of terms of reference for the Appraisers Support group (since written and approved); the need to specify the roles and responsibilities for the Medical Appraisal Administrator; and a lack of clarity regarding 2 doctors where it was not clear that they were up to date with appraisal requirements (since clarified).

d. Themes from Appraisals 2014/15

In general CWP doctors engage well with appraisal. A few doctors need a lot of support and prompting from MWM and MAA to prepare and almost always this relates to more general organisational difficulties rather than a rejection of the appraisal system.

For revalidation, NHS England highlight the importance of 6 key areas (feedback from colleagues and patients, SUIs and complaints/compliments, quality improvement and continuing professional development). Appraisal discussions in CWP and the summaries of the appraisals are consistent in covering these areas.

Several specific areas have been identified where progress has been made but there is still room for improvement. These include:

- Encouraging doctors to analyse and critically appraise their own data through reflection and discussion
- Supporting doctors to make their PDP objectives more specific, measurable and within an agreed time frame
- Collecting and analysing information from their work outside CWP with the same rigour as that within CWP – whether private practice or voluntary work

e. New developments in appraisal in 2015/2016

SARD is an electronic appraisal system introduced in CWP in Spring 2015. All but one doctor used it during this appraisal period. Doctors report finding it easy to use and intuitive both for gathering information and for appraising others: this feedback is both from CWP doctors and from doctors new to the trust who have used other electronic systems.

Over this period we have also moved from asking doctors to choose their own appraiser to allocating an appraiser. This is in line with NHS England recommendations. Appraisees who need a new appraiser are given a suggested name and an alternative – if the appraisee feels neither appraiser will be suitable, they are encouraged to discuss this with the MWM. The change has gone easily – most doctors find it helpful not to have to find an appraiser for themselves and the majority are happy to accept the first appraiser offered.

During this period we have also improved feedback to appraisers as planned. This includes:

- An annual record of the appraiser's reflection on their appraisal practice and appropriate continuing professional development
- An annual record of the appraiser's participation in appraisal calibration events such as ASG (Appraisal Support Group) meetings
- 360 feedback from appraises for each individual appraiser
- Feedback from the quality assurance of appraisals, with each appraiser receiving a 3 yearly report on strengths and challenges of their appraisal meetings and completed form 4's.

Finally we are trying to link SUIs and complaints with the appraisal process in a more timely fashion. In the past SUIs were included in the appraisal portfolio only if the doctor was named as having individual learning and when the investigation was complete – depending on the time of year of the SUI and the timing of the appraisal meeting, this could be many months after the SUI. Now we are aiming to flag up SUIs on the SARD system soon after they occur and where there is a less clear link with the individual doctor. This does not imply in any way that the doctor has done anything wrong. However doctors say they often reflect on SUIs that involve other members of the team and this can lead to changes in their own practice. Moreover putting the information on the system means that individual doctors reflect about whether there is any learning for them at a time when the incident is still clear in their mind. While this is a positive development, it represents a change in approach and can be experienced as implying criticism which may be challenging for the individual doctor.

The plans from last year have all been partially or fully implemented

:**Recommendations**	**Action**	**Responsibility**	**Time frame**	**outcome**
1. Move to completely electronic system for appraisals	SARD has now been introduced – training and support available through SARD itself and MEM	MWM, AMD	March 2016	completed
2. Ensure appraisals cover the whole of practice	AMD to contact all appraises if information on work outside CWP is not included in appraisal summary Continue with regular reminders via appraisers network and appraisal training	AMD and MWM	March 2016	Ongoing work but improvements clear
3. Ensure clear communication between appraisers and clinical directors	Survey of CDs to check this is happening reliably	AMD and MWM	Nov 2015	completed
4.Maximise effectiveness of new 360 feedback	Survey of appraises re new form	AMD and MWM	Nov 2015	completed
5. Provide feedback to appraisers regarding their effectiveness	Set up system to provide 3 yearly feedback to all appraisers	AMD and MWM	March 2016	completed
6. Ensure large enough cohort of trained case investigators	Encourage suitable candidates to seek case investigator training	MD (workforce)	July 2016	On-going work but situation saisfactory
7. Quality assure the reliability of information relating to complaints being discussed with doctors and included in appraisal portfolios	Routine scrutiny of minutes from complaints meeting to identify if doctors are personally involved and conveying this information to CDs	MD (workforce) and MWM	March 2016	On-going work but improvements clear

f. Appraisal plans for 2016/2017

Next year we hope to:

- Bed down the feedback to appraisers
- Set up a system where appraisers are paired off and sit in on another appraiser's meeting once every 3 years and reflect on this experience for their own learning and feedback to the other appraiser
- Further build on the opportunities for learning regarding the links between SUIs, complaints and appraisal
- Build links with colleagues looking to develop appraisal systems and processes for non-medical staff

3. Concerns Involving Doctors

2 doctors were formally investigated for concerns regarding conduct. One went to a hearing and a first warning was issued. The second doctor was moved to another role in the trust as a result, with an action plan. This number is in line with previous years.

A GMC hearing for a doctor dismissed by CWP last year has taken place this year (into the same issues that led to the dismissal). The outcome was a period of suspension. Non-medical staff who were asked to give evidence agreed to do so which is a testimony to their professionalism as there is no obligation on them. Both medical and non-medical witnesses found it a stressful experience linked to the nature of the hearing and loyalties to a former colleague. Support was offered by the trust. Should such a situation occur again in the future, we may benefit from anticipating these difficulties and talking to staff about them.

4. Other developments

The MAA has started in post during the last year and is line managed by the MWM. This has gone well and the medical workforce team work closely both with the Medical Education manager and with HR. In particular closer working with the Recruitment Team has helped streamline the recruitment of medical staff, making it quicker, more responsive and better understood by doctors compared to previously.

Two consultant recruitment panels were held during the year for 11 medical posts around the trust. Reflecting the national recruitment picture in psychiatry, interest has been disappointing with only 0-2 applicants per post in all but one case. The changes in locum payments have put extra pressure on unfilled posts especially since the spring of 2016.

5. Corrective Actions, Improvement Plan and Next Steps

Recommendations	Action	Responsibility	Time frame
1. ensure appraisals completed in a timely fashion	Monitor the proportion of appraisals classified as 1a, 1b and 2	MWM, AMD	March 2017
2. Support non-medical appraisal in CWP	Set up meetings with OD and HR to share lessons from rolling out medical appraisal	MWM, AMD	March 2017
3. Quality assure appraisal discussions	Set up appraiser pairs to provide feedback to each other on appraisal meetings	MWM, AMD	March 2017
4. Develop the selection process in recruitment of medical staff	Set up meetings with recuitment	MWM, AMD	June 2017

Recommendations

The board is asked to approve the report, recognizing that it will be shared with the higher level RO along with the annual audit; to approve the statement of compliance confirming that the organisation, as a designated body, is in compliance with the regulations; and support the recommendations for next steps.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Monitor Q1 Submission
Agenda ref. no:	16/17/44
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	27/07/2016
Presented by:	Tim Welch, Director of Finance and Deputy Chief Executive

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
Click here to enter text.	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

The purpose of this report is to update and inform the Board of Directors on the Trust's position in relation to the key areas of Monitor's Risk Assessment Framework which require quarterly submissions. This includes: To brief the Trust Board on the Trust position in respect of Monitor indicators and compliance, as of Quarter 1 2016-17

- To request that the Board considers the content of the Quarter 1 submission and considers the declarations required in the submission to Monitor.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	NHS Improvement Oversight Framework
Agenda ref. no:	16/17/43
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	27/07/2016
Presented by:	Tim Welch Director of Finance.

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
35T	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

NHS Improvement is consulting on a new Single Oversight Framework for both NHS trusts and NHS foundation trusts. The consultation is open until 4th August 2016. It is expected that the framework will become operational from September 2016.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The Single Oversight Framework will replace Monitor's Risk Assessment Framework for NHS foundation trusts and the Trust Development Authority's Accountability Framework for NHS trusts. The new approach has been developed alongside the CQC and NHS England in order to more clearly align regulatory processes

Assessment – *analysis and considerations of options and risks*

The purpose of the framework, guided by the foundation trust legal oversight requirements of the NHS Provider licence, is to identify where providers may benefit from, or require, improvement support across five key areas including:

- Quality of care: based on Care Quality Commission measurement, improving towards or maintaining good or outstanding ratings

- Finance and the use of resources: a new risk rating defined with metrics across financial sustainability, financial efficiency and financial controls. New shadow metrics for 16/17 include a unit cost efficiency benchmark, capital controls and agency expenditure ceiling compliance.

- Operational performance: delivery of performance targets across provider types, including Early Intervention in Psychosis and Improving Access to Psychological Therapies and percentage of harm free care and new harms across all trust services. A potential concern will be triggered when a Trust fails to meet any relevant target or standard in two consecutive months. This is significant change from the current RAF regime of a trigger following three consecutive quarters.

- Strategic change: the consultation asks for suggestions in this area, but will likely cover Sustainability and Transformation Plan contribution and delivery of strategic plans, working with health and care system partners.

- Leadership and improvement capability: measurement of effective boards and governance, continuous improvement approach and use of data. NHS Improvement is working with the Care Quality Commission with the aim of moving towards a single combined assessment of both quality and the use of resources.

Segmentation

As part of the framework, the regulator has proposed to segment the provider sector according to the 'scale of issues' faced by individual providers. This will be informed by data monitoring and, importantly, judgement based on an understanding of providers' circumstances. It is noted that segmentation 'does not in itself constitute an assessment of provider performance'.

The segment a provider is placed in will reflect the seriousness and complexity of the issues a Trust faces. It will be based on the consideration of all available information on providers – both obtained directly and from third parties. It will identify those providers with one or more triggers of potential concern and using NHS Improvement's judgement, based on relationship knowledge and/or the findings of formal or informal investigations, consider the scale of the issues faced by a provider and whether it is in breach or suspected breach of licence conditions. Providers will then be segmented as follows:

- Segment 1: No potential concerns identified
- Segment 2: Provider not in breach but still triggering a potential concern
- Segment 3 or 4: Provider in licence breach

A segmentation exercise is planned before the new framework becomes operational to identify which segment a provider is in at the time the framework goes live.

Value for money metrics

A broad value for money consideration has also been built into the draft framework. This will enable NHSI to investigate where there is evidence to suggest inefficient or uneconomical spending at a provider. Evidence for this could include national benchmarking and other areas such as high management consultancy spend.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors is asked to **note** the report and any key issues for the consultation response.

Who/ which group has approved this report for receipt at the above meeting?		Louise Brereton, Head of Corporate Affairs
Contributing authors:		35T
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	35T	35T

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	NHS Improvement – Oversight framework consultation- https://improvement.nhs.uk/resources/have-your-say-single-oversight-framework-consultation/

Background – *contextual and background information pertinent to the situation/ purpose of the report*

Monitor's Risk Assessment Framework (updated August 2015) (URL appended as appendix 1) sets out the approach Monitor will take to assess the compliance of NHS foundation trusts and to intervene where necessary. Monitor uses these ratings to assess risk to compliance with the Authorisation, guide the intensity of monitoring and signal to the NHS foundation trust the degree of concern with the specific issues identified and evaluated. Monitor requires NHS foundation trusts to report in-year, normally on a quarterly basis (dependent upon the outcome of its rating). The Board is required to submit five declarations along with its 'data' in the return.

Assessment – *analysis and considerations of options and risks*

Finance – The Board anticipates that the Trust will **not** continue to maintain a Financial Sustainability Service Risk Rating of at least 3 over the next 12 months, and will explain the reasons for this in the governance return; and the Board can confirm that the trust's capital expenditure for the financial year will not materially differ from the forecast in this financial return.

Quality Governance - The measurement area section is currently rated amber/green. Plans are in place, which are on track, to return them to Green performance from Amber/ Green. All other indicators are green [strategy, capabilities and culture and processes and structure].

Performance –The Board is also asked to note that the Trust has met all Monitor **current** performance targets for Q1.

CQC compliance action outstanding – Following receipt of the final CQC reports in Q3 2015/16, There Trust had a number of regulatory actions identified following the CQC Trustwide inspection in June 2015. The action plan has been returned to the CQC and confirms all regulatory actions have been completed by the end of Quarter 4 2015 as anticipated.

The full detail is included in **appendix one**

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board is asked to consider and confirm its final intention in relation to the Quarter 1 submission to Monitor. If the Board is unable to verify its decision at the Board meeting, the Board should seek further clarification to inform their decision before the actual submission date of 31 July 2016.

Who/ which group has approved this report for receipt at the above meeting?	Tim Welch, Director of Finance
Contributing authors:	Anne Casey, Head of Performance and Information David Wood, Associate Director of Safe Services Andy Harland, Deputy Director of Finance Louise Brereton, Head of Corporate Affairs Jo Watts, Head of Compliance

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Tim Welch	19 July 2016

Appendices provided for reference and to give supporting/ contextual information:
Provide only necessary detail, do not embed appendices, provide as separate reports

Appendix no.	Appendix title
1	Full report

Appendix 1: Monitor Q1 Submission 2016/17

1. Purpose of the report

The purpose of this report is to update and inform the Board of Directors on the Trust's position in relation to the key areas of Monitor's Risk Assessment Framework which require quarterly submissions. This includes:

- To brief the Trust Board on the Trust position in respect of Monitor indicators and compliance, as of Quarter 1 2016-17
- To request that the Board considers the content of the Quarter 1 submission and considers the declarations required in the submission to Monitor.

2. Summary

Monitor's Risk Assessment Framework (updated August 2015) (URL appended as appendix 1) sets out the approach Monitor will take to assess the compliance of NHS foundation trusts and to intervene where necessary. Monitor uses NHS foundation trusts' annual plans, in-year submissions and relevant third party reports to assign risk ratings for finance and governance.

Monitor uses these ratings to assess risk to compliance with the Authorisation, guide the intensity of monitoring and signal to the NHS foundation trust the degree of concern with the specific issues identified and evaluated.

Monitor requires NHS foundation trusts to report in-year, for targets normally on a quarterly basis and finance and activity monthly (dependent upon the outcome of its rating). The Board is required to submit further declarations along with its 'data' in this quarterly return.

The submission is split into the following areas; the Board is required to respond 'Confirmed' or 'Not Confirmed' to the following statements:

- For finance, that: The Board anticipates that the Trust will not continue to maintain a Financial Sustainability Risk Rating (FSRR) of at least 3 over the next 12 months and the Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return (Two declarations required.)

- For governance, that: The Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards. (One declaration required.)

- Otherwise: The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Risk Assessment Framework, table 3) which have not already been reported. (One declaration required.)

- Consolidated subsidiaries: Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds. (One declaration required.)

3. Discussion

3.1 Finance

The Trust will be reporting an overall Financial Sustainability Risk Rating (FSRR) of 3 at the end of June 2016. It cannot, however, sign the Governance Declaration which states 'The Board anticipates that the Trust will continue to maintain a Financial Sustainability Service Risk Rating of at least 3 over the next 12 months'. The Trust's annual plan submission for 2016/17 identifies that it will remain within the control total that it has been allocated of £0.93m deficit. This will, however have an adverse impact on our FSRR and will result in a 3 not being achieved throughout the next 12 months.

The Board can confirm that the trust's capital expenditure for the financial year will not materially differ from the forecast year end position in the NHSI financial return. Although the current variance against plan is higher than originally anticipated the plan did not factor in additional expenditure required to facilitate the proposed inpatient redesign project. The Trust will be able to cover these capital costs and remain within expenditure plan totals.

3.2 Governance

Monitor asks the Board to make one declaration in regard to governance. Monitor also assesses the targets and indicators outlined in in Appendix A of the Risk Assessment Framework (see appendix 2) and arrive at a weighted service performance score.

3.2.1 Quality Governance Framework statement

The former *Monitor* "well-led framework" (April 2015) is currently still in operation. It replaced the quality governance framework (QGF) and requires that NHS foundation trusts are assured that they are well-led. The assurance mechanisms detailed in the framework are:

- Performance against "quality governance" indicators (monitored directly by *NHS Improvement*), specifically material reductions in satisfaction or increases in sickness or turnover rates, material increases in proportion of temporary staff, and cost reductions of >5% in any given year.
- Production of an annual governance statement.
- Board governance reviews every three years (using the previous quality governance domains and current well-led framework domains).

The Trust is not required to make a specific quality governance declaration. However to support the Board in deciding which Governance declaration it wishes to make this report will continue, on a quarterly basis, to provide indicative ratings, based on the aggregated information received by the Board through the integrated governance framework process. This will be summarised annually alongside the Trust's Provider Licence compliance self-assessment declaration. The self-assessment rating, as for the Board governance review, uses the colour-coded (RAG) scoring criteria suggested by *NHS Improvement*.

Domain		Q1 2016/17 self-assessment (RAG) rating
Strategy and planning *How well is the Board setting direction for the organisation?*		
1	Does the Board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver?	GREEN
2	Is the Board sufficiently aware of potential risks to quality, sustainability and delivery of current and future services?	GREEN
Capability and culture *Is the Board taking steps to ensure it has the appropriate experience and ability, now and into the future,*		

and can it positively shape the organisation's culture to deliver care in a safe and sustainable way?		
3	Does the Board have the skills and capability to lead the organisation?	GREEN
4	Does the Board shape an open, transparent and quality-focused culture?	GREEN
5	Does the Board support continuous learning and development across the organisation?	GREEN
Process and structures *Do reporting lines and accountabilities support effective oversight of the organisation?*		
6	Are there clear roles and accountabilities in relation to Board governance (including quality governance)?	GREEN
7	Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?	GREEN
8	Does the Board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?	GREEN
Measurement *Does the Board receive appropriate, robust and timely information and does this support the leadership of the Trust?*		
9	Is appropriate information on organisational and operational performance being analysed and challenged?	AMBER/ GREEN
10	Is the Board assured of the robustness of information?	AMBER/ GREEN
SUMMATIVE SCORE		1.0

The RAG rating is explained below:

RAG	Definition
GREEN	Meets or exceeds expectations. Many elements of good practice. No major omissions.
AMBER/ GREEN	Partially meets expectations but confident in management's capacity to deliver green performance within reasonable timeframe
AMBER/ RED	Partially meets expectations but some concerns on capacity to deliver within a reasonable timeframe
RED	Does not meet expectations

In recognition that gaps in "good governance" are essentially risks to trusts' quality, operational and financial performance and therefore its strategic objectives, the Trust monitors gaps in assurance assessed as Amber/ Green (or worse) within the risk treatment plans of the strategic risk register and corporate assurance framework. This applies to the Measurement domain, equating to the Trust's current summative score of 1.0 [a score greater than 3.5 would indicate concerns regarding a Trust's quality governance arrangements]. Therefore, as at Q1 2016/17, there are no concerns regarding the Trust's quality governance arrangements.

3.2.2 Performance against targets declaration

The Board is required to make a declaration on the Trust's performance against Monitor's targets, stating whether the Trust can 'Confirm' or 'Not confirm' against the following statements:

- The Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and

- A commitment to comply with all known targets going forwards.

The table below details the Trust's current performance and intended submission against the applicable targets set within Monitor's Risk Assessment Framework. For reference purposes the figures for Quarter 4 2015-16 are included.

The Board is asked to note that the Trust has met all Monitor current performance targets.
IAPT 18 week waiting time standard - The Trust is required to report against the IAPT waiting time standard targets at 6 (75%) and 18 (95%) weeks to Monitor, in shadow format, for Q3 and Q4 of 2015/16 and from April 2016 (Q1 2016/17) this measure will be used as a formal trigger.

The quarter 1 position reported to monitor is 86.1% for 6 week (achieved) and 97.8% at 18 weeks (achieved).

Whilst the trust has achieved the IAPT 18 week waiting time standard ongoing action is being taken to address underperformance for East CCG, in particular, however monitoring tools are being shared across the trust:

i) review the access policy for this service – this is ongoing,
ii) waiting time standard performance forecast tool has been drafted further refinement of the tool is required to ensure robustness of methodology;
iii) Develop productivity reporting to assist managers with staff performance monitoring, first to follow up ratios and discharge rates – initial reports developed and continue to work with IAPT teams

As assurance Board members should note that the definitions of the targets have been verified against the defined reporting construction within the Risk Assessment Framework. All figures provided have been sense checked by at least two team members.

Target	Threshold	Quarter 1 2016/17 Performance	Quarter 4 2015/216
Care Programme Approach (CPA) follow up within 7 days of discharge	>95%	98.7%	97.6%
Care Programme Approach (CPA) formal review within 12 months	>95%	97.0%	97.0%
Minimising delayed transfers of care	<=7.5%	0.8%	0.9%
Admissions had access to crisis resolution home treatment teams	>95%	96.8%	99.3%
Meeting commitment to serve new psychosis cases by early intervention teams	>95%	143.1%	110.6%
Meeting commitment to serve new psychosis cases by early intervention teams NEW measure (scored from Q4 2015/16)	50%	86.8%	88.7%
Improving Access to Psychological Therapies - Patients referred within 6 weeks NEW measure (scored from Q3 2015/16)	75%	86.1%	82.1%
Improving Access to Psychological Therapies - Patients referred within 18 weeks NEW measure (scored from Q3 2015/16)	95%	97.8%	94.5%
Data completeness: identifiers	>97%	99.6%	99.6%
Data completeness: outcomes	>50%	86.9%	85.0%
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	Achieved	Achieved
Community care - referral to treatment information	50%	100%	100%
Community care - referral information	50%	99.8%	99.7%
Community care - activity information	50%	79.0%	81.5%
Risk of, or actual, failure to deliver mandatory services	Yes/No	No	No
CQC compliance action outstanding (as at time of submission) *This will remain red until the CQC reassess the Trust despite the required actions being completed as anticipated*	Yes/No	Yes	Yes
CQC enforcement action within last 12 months (as at time of submission)	Yes/No	No	No
CQC enforcement action [including notices] currently in effect (as at time of	Yes/No	No	No

Target	Threshold	Quarter 1 2016/17 Performance	Quarter 4 2015/216
submission)			
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	Yes/No	No	No
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	Yes/No	No	No
Overall rating from CQC inspection (as at time of submission)		Good	Good
CQC recommendation to place trust into Special Measures (as at time of submission)	Yes/No	No	No
Trust unable to declare ongoing compliance with minimum standards of CQC registration	Yes/No	No	No
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements	Yes/No	N/A	N/A

Care Quality Commission

The CQC awarded the Trust an overall rating of 'Good' following the Trustwide CQC inspection undertaken in June 2015. In early April 2016, the Trust submitted an update to the regulatory action plan to CQC confirming that the regulatory actions identified within the inspection reports have been completed. The CQC have confirmed that they will be undertaking further inspection visits to Trust services identified as "Requiring Improvement" during Quarter 1 2016 as an opportunity to review the ratings for these services. Local roadshows have been delivered during quarter 1 and are continuing over the coming weeks to enable staff to reflect on the CQC inspection process and develop local actions from recommendations made.

The Trust had a number of regulatory actions identified following the CQC Trustwide inspection in June 2015. The action plan has been returned to the CQC and confirms all regulatory actions have been completed by the end of Quarter 4 2015 as anticipated. This will remain red until the CQC reassess the Trust despite the required actions being completed as anticipated.

Results of any elections

A by-election was held in Q4 which resulted in the election of 3 governors, two service user and carer governors and one staff governor for therapies. The summer election process has commenced and will conclude in Q2.

Reports of changes to the Board of Directors or Council of Governors

Mike Maier formally took up position of Trust Chair from 1st June 2016. A process to appoint to the currently vacant NED position and for the position becoming vacant at the end of 2016 has commenced and will conclude in Q2.

4 Recommendations to the Board of Directors

The Board is asked to consider and confirm its agreement in relation to the Quarter 1 submission to Monitor;

Finance:

- The Board anticipates that the Trust will not continue to maintain a Financial Sustainability Service Risk Rating of at least 3 over the next 12 months, and will explain the reasons for this in the governance return; and
- The Board can confirm that the trust's capital expenditure for the financial year will not materially differ from the forecast in this financial return

Governance:

- The Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets and a commitment to comply with all known targets going forwards

If the Board is unable to verify its decision at the Board meeting, the Board should seek further clarification to inform their decision before the actual submission date of 31 July 2016.

5 Appendices

Appendix 1: Monitor's Risk Assessment Framework (updated August 2015)

https://www.gov.uk/government/publications/risk-assessment-framework-raf

Please note that in August 2015 a revised Risk Assessment Framework was published for 2015-16; all references are now to the 2015-16 Risk Assessment Framework.

Three new Access Time indicators are now included in the Monitor Risk Assessment Framework:

- Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral (Target: 50%). This is shadow reporting from Q4 with full reporting from Q1 2016/17

- People with common mental health conditions referred to the Improving Access to Psychological Therapies (IAPT) programme will be treated within 6 weeks of referral (Target: 75%). This is shadow reporting from Q3 with full reporting from Q1 2016/17

- People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral (Target: 95%). This is shadow reporting from Q4 with full reporting from Q1 2016/17

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Well Led Governance Review update
Agenda ref. no:	16/17/45
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	27/07/2016
Presented by:	Dr Anushta Sivananthan/ Louise Brereton

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
35T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
35T	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

As described to the Board in March 2016, the Monitor Risk Assessment Framework requires trusts to undertake an external review of their governance every three years. This requirement was added to the framework requirements in May 2014 thereby requiring trusts to have undertaken a review within the following three years, by May 2017.

Specific guidance has been issued by Monitor to provide a framework for trusts to shape and structure their reviews. It is recommended that an external organisation be appointed to undertake reviews, excluding the organisation providing the Trust's independent/ external audit function. Costs of "well-led" governance reviews are generally dependent on the level of specification; therefore it has required a tender process and identification of central funding.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

A report was provided to the Board in November 2014 to inform of the launch of the new Monitor framework and to propose a timeline for the review. This was initially proposed to commence in quarter 2 of 2015/16, however this was deferred pending the outcome of the CQC inspection undertake in June 2015. The intended consequence of this was that the review could tailored to further test the elements of governance infrastructure that were not fully tested by the CQC and to focus on any areas identified for improvement to inform the degree of the specification for the review.

A specification for the well-led review was approved by the Board of Directors in March 2016 which set out the process involved.

Assessment – *analysis and considerations of options and risks*

Since the Board last received an updated, the self-assessment element of the review process has been completed and, during June and July 2016, the review was put out to tender. Responses are now being considered.

The proposed timeline for the review is set out below:

w/c 1 August 2016	Refining the scope and approach. Initial review of self-assessment (including requests for additional evidence gathering by the Trust)
August 2016	Board Member Briefing
August- September 2016	Detailed review including; • evaluation of self-assessment evidence, • interviews/focus groups/surveys/Board and sub-committee observations, • review of Board Development Plan
October 2016	Draft report discussed and draft independent rating produced.
October 2016	Final report issued
October 2016	Board reporting and suggested action planning
End October 2016	NHS Improvement notification of completion of review.

Regular updates will be provided to the Trust throughout the review and the Board will continue to be informed of progress as required.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

The Board of Directors are asked to **note** this report and the current progress in relation to the well-led governance review.

Who/ which group has approved this report for receipt at the above meeting?	Louise Brereton, Head of Corporate Affairs
Contributing authors:	Elspeth Fergusson, Corporate Affairs Manager

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	Board of Directors	20/07/2016

Appendices provided for reference and to give supporting/ contextual information:
Provide only necessary detail, do not embed appendices, provide as separate reports

No.	Appendix title
1	Well-led review https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/422057/Well-led_framework_April_2015.pdf

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Updated Corporate Governance Manual
Agenda ref. no:	16/17/46
Report to (meeting):	Board of Directors
Action required:	Information and noting
Date of meeting:	27/07/2016
Presented by:	Louise Brereton, Head of Corporate Affairs

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	Yes
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	No
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
N/A	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

The Trust Corporate Governance Manual outlines the processes and system by which Cheshire and Wirral Partnership NHS Foundation Trust is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability and probity. The Manual is subject to an annual review to ensure that the information contained within it remains accurate and up-to-date.

This report outlines the amendments and updates which have been made, and approved and recommended by Audit Committee on 5th July 2016, as a result of this annual review.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

The annual review has been conducted and a number of minor changes have been made in relation to the contents page, job titles, regulatory title changes, formatting, page numbering, cross referencing within the document. Review dates have also been undated within the manual. There have also been a number of more material amendments and updates which have been summarised below.

Assessment – *analysis and considerations of options and risks*

The material changes made to the Corporate Governance Manual are;

- Updated Committee Structure inserted
- Updated Terms of Reference inserted
- Updated Governors Code of Conduct inserted
- Addition of information on the governance arrangements regarding Chair's action.
- The Policy on Hospitality and Gifts has been updated to include guidance on sponsorship and to incorporate the recently introduced Human Medicines Regulations and to reflect the "Sunshine Rule". Additional small amendments have also been made to provide more clarity to staff on what needs to be declared.
- Amendments to the guidance in relation to "off payroll" arrangements.
- Amendments to the guidance around management of the asset register.
- Removal of section in relation to disposal of property in reflection of the changes introduced by the HSCA 2012 and licensing regime which have removed the concept of protected assets.
- Removal of section in relation to prudential borrowing code as this is no longer a requirement
- Amendments to the Accounting Officers Memorandum in accordance with the risk assessment framework update in August 2015.
- Addition of section on occupation agreements/licences to be approved by the Deputy Director of Finance and related updates to Table A Delegated Authority and Table B Delegated Financial Limits.
- Amendment to Table A Delegated Authority to allow for approval of waiving the requirement to request tenders by the Director of Operations in the absence of the Chief Executive and by the Deputy Director of Finance in the absence of the Director of Finance. This has also been reflected in the relevant forms.
- Amendment to Table B Delegated Financial Limits to provide clarity that the threshold of £30,000 for which the Head of Estates can authorise orders applies only to capital works or revenue schemes.
- Amendments have been made to the Standing Financial Instructions in respect of tendering. This includes;
    - confirming that tendering processes are not required under the light-touch regime
    - Removing reference to a list of approved firms, as this concept is no longer current.
    - Clarification of when competitive tendering can be waived and when tendering can be waived altogether, including updating and adding the relevant forms for this (attachments 2 and 3).

The revised Corporate Governance Manual will be communicated widely across the Trust to ensure that staff are aware of the changes. It will be communicated in the following ways;

- Distribution via CWP Essential
- Announcements via the intranet
- Direct email distribution to key senior members of staff
- Email distribution to leads for governance structure meetings
- The FoI Officer will continue to promote the manual during the "market place" element of the corporate induction.
- The forms for staff to declare interests or gifts are in the process of being introduced as online forms via the staff intranet; this will be publicised at the same time as the updated corporate governance manual.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board of Directors are asked to **approve** the updated Corporate Governance Manual.

Who/ which group has approved this report for receipt at the above meeting?		David Wood, Associate Director of Safe Services
Contributing authors:		Elspeth Fergusson, Corporate Affairs Manager. Sara Vinas, FoI Officer
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	E Fergusson to L Brereton	18/07/2016

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	Corporate Governance Manual – 2016 update

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

STANDARDISED REPORT COMMUNICATION

REPORT DETAILS

Report subject:	Revision to Statement of Purpose
Agenda ref. no:	16/17/47
Report to (meeting):	Board of Directors
Action required:	Discussion and Approval
Date of meeting:	27/07/2016
Presented by:	Dr Anushta Sivananthan, Medical Director - Quality, Compliance & Assurance

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	No
Maintain and develop robust partnerships with existing and potential new stakeholders	No
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
36T	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

REPORT BRIEFING

Situation – *a concise statement of the purpose of this report*

The aim of this report is to ask the Board to formally approve the amendments to CWP's Statement of Purpose in preparation for the transfer of CAMHS tier 4 services to Ancora House. It also reflects the appointment of Mike Maier as Chair. CQC registration requires the Trust to reapply to register any new location where it carries out activity, and to register any new regulated activities. It is also a legal requirement to update the Trust's Statement of Purpose following any changes to our registration.

Background – *contextual and background information pertinent to the situation/ purpose of the report*
In light of the transfer of Tier 4 CAMHS services to Ancora House, the Trust is required to apply to CQC to formally add a new location to its existing registration and to update the statement of purpose accordingly.

Assessment – *analysis and considerations of options and risks*
The Trust has formally made the application to transfer CAMHS inpatient provision from the existing locations to the new location of Ancora House. In making the application, the Trust has confirmed that we are compliant with the requirements of the registration guidelines and detailed the findings of the comprehensive CQC inspection to CAMHS inpatient services in June 2015, whereby the service was rated as good across each of the 5 domains. In updating the statement of purpose, we have also taken the opportunity to amend the chair details to reflect the appointment of Mike Maier in June 2016.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*
The Board are asked to approve the amended Statement of Purpose.

Who/ which group has approved this report for receipt at the above meeting?		Jo Watts
Contributing authors:		36T
Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Dr A Sivananthan	12/07/2016

Appendices provided for reference and to give supporting/ contextual information: *Provide only necessary detail, do not embed appendices, provide as separate reports*	
Appendix no.	Appendix title
1	Amended Statement of Purpose

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIR'S REPORT
AUDIT COMMITTEE - 5th July 2016

The following is a summary of issues discussed and any matters for escalation from the July 2016 meeting of the Audit Committee:

Clinical Audit/Healthcare Improvement Plan 2016/17 and 2015/16 Outcomes
The Audit Committee received an overview of the Healthcare Quality Improvement Plan which incorporates the Clinical Audit plan. This included an overview of the outcomes achieved during 2015/16 including care planning, seclusion, challenging behavior, community treatment order, prone position restraint, audits in support of the national CQUIN on physical healthcare, therapeutic observation, ward environment and POMH prescribing.

The Committee was provided with an overview of the 2016/17 plan and the patient safety review programme for delivery alongside a range of bespoke reviews and the national audit programme.

Internal Audit progress update
The Audit Committee received an update on the outcomes of recent work including audits on IAPT data capture, safeguarding review and medial appraisal and evaluation. All audits received significant assurance. The Committee were provided with an overview of the audits nearing completion and those in progress for Q2 including Council of Governors effectiveness, complex case management and use of restraint interventions.

External Audit update
A technical update was also providing with recent sector updates. The annual meeting with external and internal audits is planned for September 2016.

Risk Register
The Committee reviewed the risk register but noted the issues arising from the time lag between Audit Committee and Quality Committee papers preparation. A verbal overview was given on the emerging risks and those due for archive due for discussion at Quality Committee. There were no risks for escalation.

Governance Matters

Corporate Governance Manual
The Audit Committee reviewed the amendments to the Corporate Governance Manual. These included

- Addition of information on the governance arrangements regarding Chair's action.
- Update to the Policy on Hospitality and Gifts to include guidance on sponsorship and to incorporate the recently introduced Human Medicines Regulations and to reflect the "Sunshine Rule".
- Amendments to the guidance in relation to "off payroll" arrangements.
- Amendments to the guidance around management of the asset register.
- Addition of section on occupation agreements/licences to be approved by the Deputy Director of Finance
- Amendments have been made to the Standing Financial Instructions in respect of tendering and procurement rules

All amendments will be approved by the July Board of Directors and will then be communicated to managers.

The integrated governance strategy is currently under review and will be presented to the Quality and Audit Committee meetings in September 2016.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Audit Committee

Terms of Reference

1. Constitution

The Board of Directors hereby resolves to establish a Committee to be known as the Audit Committee. The Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Duties

The Committee is responsible for:

a. Governance, risk management and internal control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievements of the Trust's objectives. It will provide an independent and objective view on internal control and probity. In addition, the Committee will monitor any formal announcements relating to its financial performance, reviewing significant financial reports and the judgements contained in them.

In particular the Committee will review the adequacy of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance to external bodies), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The finance-related policies and procedures approved by the Operational Board including Standing Orders, Standing Financial Instructions, Scheme of Delegation
- The policies and procedures for all work related to fraud and corruption as required by the NHS Protect.
- The arrangements by which Trust staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In so doing the Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

In carrying out this work the Committee will utilise the work of internal audit, external audit and other assurance functions but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

b. Internal audit

The Committee will ensure that there is an effective internal audit function established by management that meets public sector internal audit standards and NHS internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework
- Consideration of the major findings of internal audit work (and management's response) and ensuring coordination between internal and external auditors to optimise audit resources
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the Trust
- Annual review of the effectiveness of internal audit.
- Annual self-assessment of the Committee, facilitated by Internal Audit.

c. External audit

The Committee shall review the independence, objectivity and work of the external auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditor, including liaising with and making recommendations to the Council of Governors regarding the former
- The duration of each term will be three years with an option for an additional two years. once the term has expired, the appointment must be subject to open tender.
- Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan and ensure coordination with internal auditors and with other external auditors in the local health economy
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any audit work performed outside the annual audit plan, together with the appropriateness of management responses
- Approval of the engagement of the external auditor in respect of non-audit work where the cost is over £5,000, taking into account relevant ethical guidance regarding the provision of such services. The Director of Finance will inform the Committee of any non-audit engagements below this figure and in all cases the Committee will report them to the Council of Governors
- Annual review of the effectiveness of external audit.

d. Other assurance functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. It will review, appraise and report in accordance with Government Internal Audit Standards (GIAS) and best practice. These will include, but will not be limited to, reviews and reports by Department of Health arms length bodies or regulators/inspectors e.g. Care Quality Commission, NHS litigation Authority, etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc), the Local Anti-Fraud Specialist (LCFS).

In addition the Committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will

particularly include the Quality Committee and Operational Board. With regard to the former and issues around clinical risk management the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

The Committee will also review all suspensions of Standing Orders and variation or amendment to Standing Orders.

At each meeting, the Committee may wish to review any "red" rated risk from the Risk Register and may request it receives a presentation in person from the senior clinical / other professional responsible for addressing this particular risk.

The Audit Committee will report to the Board and to the Council of Governors any matters in respect of which it considers action or improvement is needed.

e. Anti- fraud

The Audit Committee shall satisfy itself that the Trust has adequate arrangements in place for countering fraud and will approve the appointment of the Local Anti-Fraud Specialist. The Committee will review the outcomes of Anti-fraud work.

f. Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements.

g. Statutory reporting (Financial & Quality Accounts)

The Audit Committee shall review the Trust's annual report and associated accounting statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Major judgemental areas
- Significant adjustments resulting from the audit
- Letter of representation
- Qualitative aspects of statutory reporting

The Committee shall monitor the integrity of the accounting statements of the Trust and any formal announcements relating to the Trust's reported performance. The Committee should also ensure that the systems for both financial and qualitative reporting to the Board, are subject to review as to completeness and accuracy of the information provided to the Board.

3. Membership

Membership will be appointed by the Board of Directors from amongst its Non-Executive members and will consist of not less than three members.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum.

The Board will appoint one of the members to be Chair and another Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent. The Chair of the Trust shall not be a member of the Committee.

a. Quorum
A quorum shall be two members.

b. Voting
Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.

c. Attendance by members
Members will be required to attend a minimum of 50% of all meetings.

d. Attendance by officers
Either the Director of Finance or the Deputy Director of Finance and appropriate internal and external audit representatives shall normally attend meetings. At least once a year the Committee will meet privately with the external and internal auditors.

The Chief Executive and other executive directors will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

The Chief Executive will also be required to attend when the Audit Committee discussed the process for assurance that supports the Annual Governance Statement

The Trust's Head of Corporate Affairs will be Secretary to the Committee and will attend to take minutes of the meeting and provide appropriate support to the Chair and the Committee members.

The Chair of the Quality Committee will have a standing invitation to attend all meetings and, additionally, officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

4. Accountability and reporting arrangements

The Audit Committee will be accountable to the Board of Directors.

The minutes of the Audit Committee will be formally recorded and submitted to the Board of Directors. The Chair of the Audit Committee shall draw to the attention of the Board of Directors any issues that require disclosure to it, or require executive action.

The Audit Committee will refer to the other two Board governance Committees (the Quality Committee and the Operational Board) matters considered by the Committee deemed relevant for their attention. The Committee will consider matters referred to it by those two governance Committees.

The Committee will report to the Board annually on its work and performance in the preceding year and, as part of this report, will provide commentary in support of the Annual Governance Statement, specifically dealing with the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts.

Trust Standing Orders and Standing Financial Instructions apply to the operation of the Audit Committee.

5. Frequency

Meetings will normally be held bi-monthly.

The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

6. Authority

The Audit Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. The Committee is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, subject always to compliance with Trust delegated authorities.

7. Monitoring effectiveness

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.

8. Administration

The Committee shall be supported administratively by the Company Secretary whose duties in this respect will include:

- Agreement of the agenda with the Chair
- Collation and review of reports
- Distribution of agenda and reports to members in accordance with the Trust's corporate governance standards
- Taking the minutes of the meeting
- Preparing a record of actions
- Advising the Committee on pertinent areas.

9. Review

These terms of reference will be reviewed at least annually by the Committee.

Date reviewed by Committee	March 2016
Date approved by Board of Directors	May 2016
Review date	March 2017

10. Version control

Version control	Date	Comments
1	7 July 2010	Amends made by Audit Committee members and by Company Secretary following review of (as yet unpublished) Department of Health Audit Committee Handbook 2010
2	26 July 2010	Amends made by Audit Committee members and Deputy Director of Finance
3	27 July 2010	Further amends made by Audit Committee members

4	4 May 2011	Further amends made by Audit Committee members
5	6 March 2012	Further amends made by Audit Committee members
6	5 March 2013	Reviewed by Audit Committee
7	1st May 2014	Reviewed by Audit Committee, amendments agreed
8	5th May 2015	Reviewed by Audit Committee, amendments agreed (references to anti-fraud and annual governance statement)
9	1st March 2016	Amendment to section 2a.

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

CHAIR'S REPORT –
QUALITY COMMITTEE
6 JULY 2016

The following issues and exceptions were raised at the Quality Committee, which require escalation to the Board of Directors:

- **Strategic risk register**
  Two new risks in relation to safeguarding have been added to the strategic risk register, replacing the previous risk with newly modelled, separate risks in relation to distinct elements of safeguarding: (i) training and (ii) implementation of recommendations from national reviews. Mitigating actions around the re-constructed risk around data quality and completeness, as reported to the last meeting of the Board of Directors, has positively reduced the risk score from 20 to 16. The Medical Director and Associate Director of Safe Services have facilitated the process of deconstructing and/ or archiving longstanding risks by meeting with a number of Associate Directors and also discussion at Operational Board to review the mitigations being identified as risks to the Trust's strategic objectives for contemporaneity and impact.
  The Board of Directors now receives the corporate assurance framework quarterly (not scheduled for July) and so this will be updated further in September by reviews at the next Quality Committee meeting.

- **Quality impact on community physical health services due to lack of transitional funding and the application of the deflator**
  The Quality Committee discussed the quality impacts of responding to how commissioned physical health services can operate safely within the £20.2 million funding it receives. The quality impacts are potentially significant and as such are being discussed at the Board of Directors meeting in July for agreement about supporting a system-wide approach to mitigating these impacts to the lowest residual impact possible.
  The Board of Directors is asked to note the discussion about quality impact undertaken by the Quality Committee.

- **CAMHS Tier 4 service improvement**
  A presentation was received by the Clinical Director on the care and quality impacts (risks, challenges and opportunities) of the future model of care for CAMHS Tier 4. CWP has invested in co-locating current inpatient provision to Ancora House and there are opportunities to be flexible and expand, building on comparative benchmarked shorter length of stays, fewer readmissions, improvements in clinical presentation and functioning, and higher number of young people treated per year. Assurance was received around frameworks in place to mitigate risks associated with management of self-harm, implementation of new models of care associated with the move to Ancora House, the implications of staff turnover, and education needs for over 16s.
  The Board of Directors is asked to note the Quality Committee's ongoing role in receiving assurance around care and quality impacts of this (and other) operational plan priority.

- **Complex Recovery Assessment and Consultation team outcomes**
  The CRAC team comprises experienced professionals with skills and expertise in complex care management. The Board of Directors invested in this team as a Trustwide service as part of the CWP Zero Harm strategy. The Quality Committee received a presentation on the outcomes of this service, to assure the Board of return on investment. A number of significant quality outcomes were demonstrated to the Quality Committee. CRAC has longitudinal quantitative and qualitative data on all complex cases from those in acute wards not discharged by 40 days to those out of area. The CRAC role ensures that CWP is constantly updated and aware of risks and options for complex inpatients and is in the best position to select the best option for individuals on a person-centred care basis to reduce clinical and financial risks and promote recovery.
  The Board of Directors is asked to note the positive outcomes from its investment in this service.

- **Care Quality Commission 5-year strategy**
  The CQC inspection framework/ approach is currently being developed and will come into effect from 2017/18, as outlined in their strategy document "Shaping the future, CQC's strategy for 2016 to 2021". There will be a more targeted, responsive and collaborative approach to regulation, so that more people get high-quality care.
  The Board of Directors is asked to note the CQC 5-year strategy and to be aware that CWP's own internal compliance and assurance approach has been aligned to CQC's proposed developments.

Dr Jim O'Connor
Non Executive Director/ Chair, Quality Committee